Public Petitions Committee – a template for e-petitions

Should you wish to submit an e-petition allowing signatures to be gathered on-line on the Public Petitions Committee e-petitioner web pages please complete the template below. Before submitting your e-petition please consult the Guidance on submission of public petitions for advice on what is and is not admissible. You may also seek advice from the Clerk to the Committee whose contact details can be found at the end of this form.

**Details of principal petitioner:**
Please enter the name of person and organisation raising the petition, including a contact address where correspondence should be sent to.

| James A. Mackie |

**Text of petition:**
The petition should clearly state what action the petitioner wishes the Parliament to take in no more than 5 lines of text, e.g.

The petitioner requests that the Scottish Parliament considers and debates the implications of the proposed Agenda for Change legislation for Speech and Language Therapy Services and service users within the NHS

"The Petitioner requests that the Scottish Parliament examines the workings of the Mental Health (Care and Treatment) (Scotland) Act 2003 Act and, in particular, the making available of legal representation and legal aid to patients detained in Psychiatric Wards and/or released to the Community and under the influence of prescribed antipsychotic and/or brain altering type drugs."

**Period for gathering signatures:**
Please enter the closing date for gathering signatures on your petition, which we would usually recommend is a period of between 4-6 weeks

| Closing date: 26 September, 2005 |
Psychiatry is a medicinal discipline founded purely on theory. There are no tests of any kind for conditions such as Bipolar Disorder, Schizophrenia, Manic Depression, etc. Diagnoses are purely on the opinion and "experience" of the examining psychiatrist. Physical illnesses as well as nutritional deficiencies produce symptoms that may appear that the patient has a "mental illness". However, at present, psychiatrists within the NHS ignore these possibilities and treat patients with drugs that have severe mental and physical side effects, even death, in patients. Heroin, Cocaine, LSD and "E" are some illegal street drugs that started life as licensed and prescribed psychiatric drugs. We all know the side effect of taking these drugs over an extended period of time. Psychiatric drugs are designed to alter the way the brain works. Patients on prescribed antipsychotic drugs are often heavily sedated by the drugs and are unable to make decisions about their condition, orientation or instruct others including lawyers.

Modern psychiatry is believed to have partly evolved from a) An accident that happened to a Phineas Gage,( http://www.deakin.edu.au/hbs/GAGEPAGE/) a foreman on an American railway line construction. An explosion blew a 3 foot long tapered metal shaft through his chin and out through his head. He survived the accident but it severely changed his personality. Lobotomy treatment for mentally ill patients stems from that accident and b) work done to remove brain tumours from other patients. ECT and drug therapy are all forms of lobotomy. Requests to the Health Ministers of the Scottish Executive and the UK Government have failed to produce scientific papers showing that Lobotomy and ECT are scientific clinical treatments.

All though there is no official audit of mental health services in Scotland, mental health services are believed to cost the tax payer over £4 billion pounds a year. This cost covers drugs, staff, hospital wards and care in the community. That figure does not include the cost to the community through the loss of employment abilities of patients if they were treated holistically and able to be employed.

Psychiatrists have the legal right to detain people in secure wards (under section) if the psychiatrist thinks, in his "opinion", the patient has a mental illness. Over 90% of all people detained under a section have never appeared in court and have committed no crime. Their eventual release is at the discretion of the psychiatrist. A patient can be detained in a psychiatric ward under section for life.

Once an individual has attained the age of 16 years they are legally an adult and the parents and/or spouse or family members have no legal rights to represent them or give instructions to a legal representative on their behalf. A psychiatrist and/or his staff have no legal obligation to discuss treatments etc with a patients family etc. A spouse has no legal rights over a patient detained under a section. A patient in a psychiatric ward does not have the automatic right to a second opinion whether it is mental health or general health matters. A patient can appeal against a Section order. However, it is the experience of many that they cannot get lawyers to act for them. Few lawyers specialise in Mental Health. Even fewer work on legal aid. Most I have spoken to say that trying to get legal aid to represent such clients is almost impossible. Legal Aid curtails the distance that lawyers can travel to see clients in psychiatric wards. For example a lawyer in Dundee who specialises in Mental Health law said she would not get legal aid to travel to Galashields even although the patient could not get a lawyer experienced in Mental Health Law within Lothian and Borders area. If one contacts the Law Society looking for a legal representative who specialises in Mental Health Law, they will only give the name of three law firms in the area of the patient who claim that they offer services in Mental Health cases. The Law Societies registration of interests of law firms is not kept up to date therefore it is difficult to find a lawyer.

If a psychiatrist states that a patient is too "ill" to give instructions, a lawyer cannot act on behalf of the patient. As said earlier if the patient is over 16 years of age and therefore classed as an adult, no person other than a Welfare Guardian can give instructions to a lawyer to act for the patient. Even in that situation, their powers are limited. Families do suffer when a family member is detained in a psychiatric ward. Psychiatrists and ward staff rarely communicate with the family, whether it is parents and/or spouces. If familv members ask too many questions and/or point out the side effects
drugs are having on the patients it is not unusual for them to be banned from visiting the patient. A psychiatrist can ban visitors to a patient in a psychiatrist ward at any time without giving any reasons and with no right of appeal.

In many cases the family and/or spouse suffer severe stress and/or depression over the treatment of the patient. Should a patient be lucky enough to have a lawyer to act for them, that lawyer cannot act on behalf of the family member as well. In short, it is almost impossible for a patient detained under section in a psychiatric ward to get legal representation.

The Petitioner therefore requests the Scottish Executive to:

Review the workings of the Mental Health Legislation;

Give the patients, named person and/or parent/family member and/or spouse the power to instruct lawyers on behalf of a patient detained under section;

Give the patients named person, parent/family member and/or spouse the authority to demand a second opinion on the mental and general health of a patient detained under a section order;

To allow specialist lawyers greater leeway under legal aid funding to represent patients with an alleged mental health problem;

To give patients and/or there named person, parent/family member and/or spouse powers to ensure that a psychiatrist must acknowledge and act on the advice of specialists in the field of a problem diagnosed in a person detained under a section order issued under the Mental Health Acts.

To authorise an external Audit of Mental health Services in Scotland which would include an audit of treatments, side effects suffered by patients prescribed antipsychotic drugs and the fate of patients released into "care in the Community" facilities and the total cost to the taxpayer.

To ensure that the Law Society has accurate records of member activities and that it can supply the names of specialist lawyers rather than company names.
Action taken to resolve issues of concern before submitting an e-petition:

Before submitting a petition to the Parliament, petitioners are expected to have made an attempt to resolve their issues of concern, by for example, making representations to the Scottish Executive or seeking the assistance of locally elected representatives, such as councillors, MSPs and MSPs. Details of those approached should be entered.

Contact with parents, family, QC's, lawyers, Law Society and MSP's

Comments to stimulate on-line discussion:

Please provide at least one comment to set the scene for an on-line discussion on the petition, not exceeding 10 lines of text.

Psychiatric medicine is based purely on theory and the “expertise” and “opinion” of the examining physician. There are no current tests available to detect conditions classed as a “mental illness”. Failure by psychiatrists to accept that many signs of a “mental illness” can be caused by a physical problem and/or nutritional deficiencies and/or allergies leads to misdiagnoses and wrongful treatments with drugs that cause permanent mental and physical side effects as well as a far higher risk of premature death. Patients diagnosed as having a “mental health ailment” find it almost impossible to get legal representation because of a shortage of specialist lawyers and because of the restrictions imposed by the Legal Aid Board. This is a breach of Human Rights and can lead to abuse of mental health facilities.

Petitioners appearing before the Committee

The Convener of the Committee may invite petitioners to appear before the Public Petitions Committee to speak in support of their petition. Such an invitation will only be made if the Convener considers this would be useful in facilitating the Committee's consideration of the petition. It should be noted that due to the large volume of petitions it has to consider, the Committee is not able to invite all petitioners to appear before the Committee to speak in support
of their petition.

Please indicate below if you do NOT wish to make a brief statement before the Committee when it comes to consider your petition.

I do NOT wish to make a brief statement before the Committee ☐

Signature of principal petitioner:
When satisfied that your petition meets all the criteria outlined in the Guidance on submission of public petitions, the principal petitioner should sign and date the form in the box below. Other signatures gathered should be appended to this form.

Signature: [Signature]

Date: 14/07/05

For advice on the content and wording of your e-petition please contact:

The Clerk to the Public Petitions Committee
The Scottish Parliament
Edinburgh
EH99 1SP
Tel: 0131 348 5186 Fax: 0131 348 5088
e-mail: petitions@scottish.parliament.uk

Note
Completed e-petition forms should also be sent to petitions@scottish.parliament.uk.
LS146/sc/mmg

Dr. James Johnston,
Clerk to the Public Petitions Committee,
TG.01 Parliamentary Headquarters,
The Scottish Parliament,
EDINBURGH EH99 1SP
By e-mail.

Dear Dr. Johnston,

SCOTTISH PARLIAMENT PUBLIC PETITIONS COMMITTEE – CONSIDERATION PE889

I am writing to you on behalf of the Legal Aid Solicitors Committee and the Mental Health and Disability Sub-Committee of the Law Society of Scotland in order to provide information in relation to the concerns raised in the above Public Petition.

It is the view of the Society that the persons referred to in the Petition should have adequate legal representation and that any measure to improve representation would be welcomed.

The Petition also raises the question of the Law Society of Scotland keeping accurate records of the activities and names of specialist lawyers accredited in mental health law. The Society has implemented a new accreditation process for members of the Society who are specialists in mental health law. This process involves practitioners submitting forms and other evidence to the Society in order that they may be considered for accreditation or re-accreditation by a panel of expert lawyers who are currently drawn from the membership of the Mental Health and Disability Sub-Committee.

Applications from practitioners for accreditation and re-accreditation in this particular specialism are currently being received and the Society expects to compile records of specialist over the coming months. Therefore it is hoped that in the near future members of the public will be able to contact the Society to have access to this information.

I hope this is helpful.

Yours sincerely,

Samuel Condry
Law Reform Assistant
SAMH Response to Public Petitions Committee
On Petition PE889

SAMH
The Scottish Association for Mental Health (SAMH) is the leading voluntary
sector organisation in its field in Scotland providing accommodation, support,
training, employment and structured day services for people with mental
health and related problems including homelessness, addictions and other
forms of social exclusion. In addition, we operate an information service,
offering general mental health information and specialist legal and benefits
advice.

SAMH campaigns on a wide range of mental health issues, and works to
challenge the stigma and discrimination experienced by people who live with
mental health problems, influence policy and improve care services in
Scotland.

COMMENTS

SAMH welcomes the opportunity to provide its views to the Committee on
Petition PE889. We share the Committee’s view that it would be premature
for the Parliament to ‘examine the workings’ of the 2003 Act given that
implementation commenced only on 5th October 05.

The Mental Welfare Commission for Scotland has a statutory duty to monitor
the operation of the Act, and to bring matters regarding its operation to the
attention of Scottish Ministers and others as appropriate. We understand that
the Scottish Executive intends to publish its research strategy later this month.

SAMH regularly receives calls to our national telephone Information Service
from people seeking advice and information about their rights in relation to
compulsory powers in mental health legislation. On the particular issue of
legal representation for those subject to compulsion, our experience in
relation to the previous legislation (the Mental Health (Scotland) Act 1984)
was that whilst people were generally able to secure legal representation,
they were sometimes dissatisfied with the standard of that representation,
particularly in cases where they were unsuccessful in challenging their
detention under the Act. Concerns about legal representation included
perceived lack of knowledge of the legislation; lack of experience or
understanding in relation to mental health; lack of consistency regarding
which solicitor in a firm was responsible for the case.

Our general impression is that the availability anc standard of legal
representation in relation to mental health varies considerably. There are
solicitors who are highly skilled and experienced in this area; there are others
who are less experienced but willing to represent clients; and the remainder
do not offer mental health representation. It certainly appears that mental health law is not a popular area in which to practice, despite the fact that non-means tested legal advice and assistance is available for proceedings before the Mental Health Tribunal (and previously the Sheriff Court) through the Assistance By Way of Representation (ABWOR) scheme.

Where a person does not have the capacity to instruct legal representation, the Tribunal may appoint a curator ad litem to represent the patient’s interests in Tribunal proceedings¹.

The Law Society of Scotland provides details of firms of solicitors which offer representation in particular areas. Our Information Service relies on this information when responding to requests from people looking for legal representation. The Society’s website indicates that 245 out of 1794 firms across Scotland offer ‘mental health’ representation (on a general search through its ‘firms and branches’ link). More detailed information about the level of experience claimed in particular areas by certain firms and the name of the contact person at each firm, is available through a ‘mental health details’ link on its homepage. The Society relies on firms to provide this information. It is not in a position to require firms to practice in a particular area.

We are also aware that the Law Society has recently introduced an accreditation scheme for solicitors covering practice in relation to mental health legislation. It remains to be seen whether a significant number of solicitors will seek accreditation in this area.

We believe that it is too early to say what impact the introduction of the 2003 Act will have on the availability or quality of legal representation. However, as people may face significant restrictions on their liberty and freedom to make choices as a result of powers in the Act, access to legal representation is vital in ensuring that the use of these powers can be challenged. We therefore believe that this is an area which should be monitored as implementation progresses.

SAMH Policy and Information Directorate
December 05

¹ The Mental Health Tribunal for Scotland (Practice and Procedure) (No. 2) Rules 2005, SSI 2005, No 519, Rule 55
To the Scottish Petition for an

We, the undersigned, are concerned that traffic on the trunk road between the North-east’s two major cities, Aberdeen and Inverness, is seriously impeded at Elgin due to the inadequacies of the existing road, harming the economy of the area.

We therefore call on the Scottish Parliament to urge the Scottish Executive to include a bypass for Elgin in the programme for improvements to the A96 as a matter of urgency.

Signature          Address          Name (printed)

Principal petitioner: Pauline Taylor, Editor, “The Northern Scot.”
Dear Richard

Thank you for your recent letter asking for an update on developments in respect of the Elgin Bypass and the Strategic Projects Review (SPR).

For the remainder of this decade we are committed to delivering the current transport investment programme, which includes more than 40 major road improvement projects. Delivering this programme is a huge commitment of funding and resources and it is unlikely that any major new projects will be considered in advance of the SPR.

While the Elgin Bypass is not included in the current investment programme, we are working closely with the Highlands and Islands Transport Partnership (HITRANS) and the North East Scotland Transport Partnership (NESTRANS) in a multi-modal corridor study to identify the future transport needs of the A96 corridor.

The SPR is due to commence later this year. The review will cover all transport modes and will provide an opportunity to support Scotland’s growing economy by considering, planning and prioritising the infrastructure requirements and investment priorities over the period to 2020 and beyond.

Transport Scotland has the operational responsibility for this area, and can be contacted for more information if required.

I hope that this is helpful.

Yours sincerely

JACKIE MCCAIG
Petition regarding surreptitious medication for consideration by the Public Petitions Committee of the Scottish Parliament

Details of petitioner
Name: W. Hunter Watson

Petition
The petitioner requests that the Scottish Parliament provides adequate safeguards against vulnerable adults being given, by surreptitious means, unwanted, unnecessary and potentially harmful medication.

Previous action taken
Through my MSP, Nicol Stephen, I have corresponded about this issue with several members of the Scottish Executive including Mary Mulligan, Andy Kerr and Rhona Brankin. I have also corresponded directly with opposition MSPs and responded to various consultation exercises making known my views about surreptitious medication.

Request to speak
I would welcome an opportunity to make a brief statement to the Public Petitions Committee.

Signature:

Date: 5 May 2005
Dear Michael,

Thank you for your letter of 14 December seeking further comments for the Committee’s consideration of Public Petition PE867 in the light of responses that the Committee has received from SAMH, ENABLE Scotland and Alzheimer Scotland.

I would want to say first of all that we would be concerned if medication was being administered to patients in nursing homes, covertly or otherwise, without lawful authority, or if patients were being sedated simply to make life easier for staff rather than for therapeutic purposes. As my letter of 30 October made clear, a comprehensive range of safeguards is in place to ensure that such things do not happen.

That letter touched on various guidelines and codes of practice, the Care Commission and National Care Standards, Part 5 of the Adults with Incapacity (Scotland) Act 2000, and the forthcoming Vulnerable Adults Bill.

**Care Commission returns**

In their response SAMH say that not all service providers comply with the requirement to notify the Care Commission at least once a year of any instance in which medication has been administered to a service user without consent, and that the Care Commission has not analysed the information received.

Most types of care service providers (including care homes for older people) are required under Articles 19 and 20 of the Regulation of Care (Requirements as to Care Services) (Scotland)
Regulations 2002 to make returns to the Care Commission at least once annually of instances where medication has been administered without consent.

It is worth noting that some types of care services (for example childcare agencies and adoption and fostering services) which are not involved in the administration of medication are exempt from making returns.

Where a care service provider to whom the regulation applies fails to make a return, or where the information provided is incomplete, I understand from the Care Commission that it will follow this up with the provider and investigate it during inspection.

There is no statutory responsibility on the Care Commission to analyse returns in relation to medication. However, I believe that the Care Commission looks at all the returns and, where there are concerns, officers will follow these up with the provider.

**Adults with Incapacity (Scotland) Act 2000**

I turn now to the issues raised about the Adults with Incapacity (Scotland) Act 2000. As set out in my letter to the Committee of 30 October, the further consultation with key stakeholders to revise the Code of Practice which accompanies Part 5 of the Act officially ended on 28 October. The draft revised Code, which was issued as part of the consultation, included guidance on the use of covert/surreptitious administration of drugs. This issue attracted significant comment from consultees, who included organisations representing patients, as well as the BMA and other organisations representing healthcare professionals. SAMH, Alzheimer Scotland and ENABLE Scotland were all invited to submit their comments.

Mr Hunter Watson also submitted comments to the consultation. Many of the same issues raised in submissions to the Committee were also raised during the formal consultation. My officials are currently considering all the comments raised before finalising the revised Part 5 Code of Practice.

We had hoped the revised Code would have been published before the end of last year but this has not proved possible. Let me assure you, however, that my officials are working hard to finalise and publish the revised Code as soon as possible.

The Committee may also wish to note that two changes to section 47 of the Adults with Incapacity (Scotland) Act 2000 were enacted on 19 December, with the coming into force of section 35 of the Smoking, Health and Social Care (Scotland) Act 2005. The first change extends the authority to grant a certificate under section 47(1) to health professionals who have relevant qualifications and training to assess incapacity. The second change extends the maximum duration of a section 47 certificate from 1 year to 3 years in certain prescribed circumstances. These will reduce significantly the burden on doctors, and also make it easier for adults who lack the capacity to consent to treatment, to receive appropriate and timely healthcare treatment.

The Executive expects doctors and others to operate within the law and this includes fulfilling their obligations under Part 5. Prior to the Act, to treat a patient without consent other than in an emergency could be considered an assault. Failure to follow the Act may therefore affect their defence in the event of criminal charges being brought by, or on behalf of, a patient.
Mental Health (Care and Treatment) (Scotland) Act 2003

SAMH refer to the safeguards in the Mental Health (Care and Treatment) (Scotland) Act 2003. Mentally disordered persons may be given treatment on a compulsory basis under that Act. Since patients may be treated against their will, the Act contains safeguards about the types of treatment that can be given to a patient and when a second opinion must be obtained from an independent doctor appointed by the Mental Welfare Commission.

I should make it clear, however, that the Act is only relevant to those patients subject to compulsion under the Act, which will include only a very small number of people resident in Care Homes.

Although the Act does not specifically address the issue of covert medication, the Commission and other professionals recognise that there may be exceptional circumstances where the disguised administration of medication could be considered, for example where there is a very clear medical necessity for the treatment and this may be the least invasive or distressing way to administer necessary treatment.

Under the Act, each patient has a responsible medical officer (RMO) in charge of their care and treatment. The Code of Practice makes clear that best practice would be for the patient's multi-disciplinary team to work together to co-ordinate and agree on all aspects of the patient's care and treatment. The Act also provides that any professional discharging functions under the Act, such as a doctor, nurse, social worker or Tribunal member, must take into account the past and present views of the patient, the patient's named person, carers, and any guardian or welfare attorney. Every patient also has a legal right of access to independent advocacy, which can help them understand the options available and to convey their views on their behalf. Where the patient has made a valid advance statement, the wishes specified in it must also be taken into consideration.

In relation to medical treatment, the Act specifies particular times when the RMO must have regard to the views of the patient and the patient's named person in reaching their decision about the patient's treatment.

There are also certain times when the patient, or their named person, can appeal to the Tribunal to have their case reviewed or to have the requirements of the order changed.

Second opinion and/or a report to the Mental Welfare Commission

Alzheimer Scotland suggest that regulations on treatments under Part 5 of the Adults with Incapacity (Scotland) Act (2000) (for example, treatments involving restraint or administration without the knowledge of the adult) might be amended to require either a second opinion and/or a report to the Mental Welfare Commission.

The Commission have advised that they would be unable to cope with the increased workload should second opinions for treatments involving restraint or the administration of medication without the knowledge of the adult be sought from a Designated Medical Practitioner. I am therefore of the view that regulating to provide for second opinions could cause practical problems and also place an undue burden on the system, and would not be proportionate to concerns raised.

The Mental Welfare Commission have also advised that they do not wish to receive a report of each treatment involving restraint or administration without the knowledge of the adult. They consider that the Care Commission have a duty to ensure that proper procedures and policies are in place.
The Mental Health (Care and Treatment) Scotland Act 2003 provides for the formal review of patients on longer term orders. The Act places a duty on the patient’s RMO to conduct mandatory reviews of such orders and to review orders on a “time to time” basis to examine whether it is necessary for the patient to continue to be subject to compulsory measures or if it is necessary to revoke or vary the order. The patient and others acting on their behalf may apply to the Tribunal at specific times to revoke or vary specified orders. Although the Mental Welfare Commission also have the power to revoke certain orders, the Commission have advised that these cases would be referred to the Tribunal.

I hope the Committee finds these further comments helpful.

LEWIS MACDONALD
Ref: NS/AN/j:leg/let/ns/06/mcmahon0702

Date: 7 February 2006

Michael McMahon MSP
Convenor of the Public Petitions Committee
TG.01
Parliamentary Headquarters
Edinburgh
EH99 1SP

Dear Mr McMahon

Petition PE867

Thank you for your letter of 14 December 2005 in connection with the above petition. I am attaching a copy of our response. This has also been sent by e-mail.

If you need any more information then please let me know.

Yours sincerely

Nicola Smith
Solicitor

Enc
ENABLE Scotland

RESPONSE TO SCOTTISH PARLIAMENT PUBLIC PETITIONS COMMITTEE – PE867

6 February 2006

Introduction

In 2000 the Scottish Executive published a review of learning disability called “The Same as You?”. This estimated there were 120,000 people with learning disabilities in Scotland including 20,000 people who need a lot of help with their daily life. ENABLE Scotland is the largest voluntary organisation in Scotland of and for people with learning disabilities. We have a strong voluntary network with around 4000 members in 68 local branches as well as 500 national members throughout Scotland. Around a third of our members have a learning disability.

We are pleased to be given the opportunity to comment on PE867. This Petition raises important ethical, moral and legal issues about medical treatment that are of relevance to people with learning disabilities.

Summary

• In situations where a person with a learning disability lacks the capacity to make decisions about medical treatment then Part 5 of the Adults with Incapacity (Scotland) Act 2000 should be used.

• In many cases care workers and families actually administer medication. They require clear medical guidance. When doctors sign a Certificate of Incapacity under Part 5 they should be required to specify that medication is to be given covertly and the way in which this is to be done.

• In situations where a person with a learning disability has capacity to make decisions about medical treatment then they should not be given medication covertly unless the law clearly authorises this. They have the right to consent to or refuse medical treatment.

• Clear guidance should be issued on when covert medication is appropriate. The BMA’s response implies there is a general rights to medicate competent adults in some circumstances. We do not understand this to be the correct legal position.

• Additional safeguards may be necessary where drugs with the primary aim of controlling mood or behaviour are prescribed.

• There is a lack of research and information on the scale of the issue would be helpful.
even if it is not widely regarded as being in their best interests. However, the responses to the petition indicate there may be some confusion in this area. The BMA’s response states “...other than as a last resort in the kind of circumstances where a competent patient is violent or threatening peoples safety and when covert medication would avoid the risks of harm possibly associated with the use of a physical restraint”. It goes on to say “...it is not ethically acceptable to administer medication to a competent person without first explaining the implications and gaining the individuals co operation – other than as a last resort and where it will clearly benefit the patient”. This implies that in some circumstances doctors have a general right to treat competent patients covertly outwith mental health law. It would be helpful if further information was provided about these statements as we do not understand this to reflect the legal position.

The National Care Standards: Care Homes for People with Learning Disabilities give some guidance on covert medication. For example, they state “...staff will not give medication except in accordance with the law. Even where the law allows medication to be given without consent it will not be given in a disguised form unless you have refused and your health is at risk and this will be recorded”. However, there are no details about the circumstances in which the law does permit covert medication. It would be helpful if this was clearly set out.

As other organisations have pointed out there is a lack of research in this field. SAMH note that the Care Commission has to be notified annually of “...any instance in which medication has been administered to a service sure without the consent of that service user or of a person duly authorised to consent on the service users behalf”. Such information would be very useful in clarifying the scale of the issue and the circumstances in which covert medication is given and we agree it should be collected and analysed. This would assist any decision about the type of regulation that is needed.
Petition 867: Request for adequate safeguards against vulnerable adults being given by surreptitious means unwanted, unnecessary and potentially harmful medication

W. Hunter Watson  
April 2006

Summary
This paper expands on the case made previously for adequate safeguards. It points out that for some this could literally be a matter of life or death. It explains why the safeguards within the provisions of the Adults with Incapacity Act and the Regulation of Care Act are insufficient. It suggests that people should not have the worry that drugs might be concealed in their food or drink if eventually they are forced to enter a care home. It also suggests that the Mental Welfare Commission should change its advice on the use of medication as a restraint. It concludes with a set of recommendations.

The case for adequate safeguards
Vulnerable adults include those who have dementia, learning disabilities or some form of mental illness. Also included are those who are elderly or who have suffered a head injury or a stroke. It must not be assumed that by virtue of being in any of those categories an adult lacks the capacity to withhold consent to medical treatment.

The letter from BMA Scotland dated 9 February 2006 to the Public petitions Committee changed the advice offered in its letter of 11 October 2005. Notwithstanding the reference in the BMA handbook of ethics and law to “a grey area”, BMA Scotland is now putting forward the view that (in order to comply with the law) “competent adults cannot be given covert medication”. It is to be hoped that the Scottish Parliament will accept this advice and not imply that doctors should be permitted to act illegally. It should be noted that, according to evidence presented to the Committee by Alzheimers Scotland, this seems to have happened in England where some adults with “mild or no cognitive impairment” were reported to have been given medicine covertly. It is, of course, possible that the doctor(s) concerned believed that those adults did lack capacity: the assessment of capacity is not a straightforward procedure and even so-called experts can disagree over assessments. If an adult is to be deprived of his or her right to refuse medication on the grounds of incapacity then, at a minimum, there should be a requirement for more than one person to be involved in the assessment of that adult’s capacity. Legal advice should be sought on this issue since any decision of the Scottish Parliament must be compatible with the European Convention on Human Rights. By virtue of Article 6, the right to a hearing, it may be that it should be made clear that those treating an adult should either respect any refusal of treatment or they should apply for compulsory powers under either the 2003 Mental Health Act or Part 6 of the Adults with Incapacity Act. Given that medication errors cause thousands of deaths each year, there should be no question of the convenience of doctors taking precedence over the safety of patients.

In its letter of 11 October 2005 to the Public Petition Committee B M A Scotland advised that “covert administration of medication is never justified for the convenience of those providing treatment”. It is to be hoped that the Scottish Executive accepts this advice and takes steps to stop some care homes from concealing antipsychotic drugs in the food or drink of residents in order to make them easier to manage. As was pointed out in my paper “Surreptitious Medication 2”, a large-scale survey revealed that most people who had taken antipsychotic drugs had experienced unpleasant side-effects. Since the production of that paper more information has emerged. In a report in the Sunday Telegraph of 15 January 2006 it was stated that“.... official figures show in 35 per cent increase in adverse reactions to antipsychotics among those aged 75 and over between 1997 and 2004, and an 83 per cent rise in fatalities linked to those drugs.”

On several occasions the Scottish Executive has been made aware of concerns about the inappropriate use of antipsychotic drugs in care homes but no action seems to have been taken. For example, the Pre-Inspection Returns to be completed by care homes contain no questions about those drugs. Further, responding to concerns about the use of antipsychotic drugs in care homes, Frank McAveety, the then Deputy Health Minister, wrote in a letter to Nicol Stephen, MSP, dated 13 March 2003:

“The Care Commission is aware of issues surrounding the inappropriate use of medication, but it is outwith the Care Commission’s remit to instruct a doctor about prescribing”.

That response ignored the fact that antipsychotic drugs are normally prescribed to care home residents for the purpose of restraint and that this normally happens because of a request from care home staff. Care Commission inspectors could legitimately enquire whether staff had been complying with relevant care standards and the principles of the Adults with Incapacity Act.
As noted in my paper "Surreptitious Medication", in 1992 bulk supplies of the document "A guide to consent to examination, investigation, treatment or operation" were issued to all Health Boards in Scotland for local distribution. The document made clear that, unless being treated under the 1984 Mental Health Act, a patient had the right under common law to withhold consent to treatment. The third section of the document made clear that even a patient with a mental illness or a mental handicap had that right. Some doctors, however, chose to ignore the law regarding consent as set out in the guide. They claimed that the document was only a guide and that if a patient lacked the capacity to give consent then the patient also lacked the capacity to withhold consent (the doctor being the sole judge of capacity).

I became aware of such matters in 1997 when I observed a care assistant surreptitiously squirting a drug into a glass of juice that she was about to offer my mother who was, by then, a resident in a nursing home. When I later drew the attention of a nurse to the law concerning consent I was told that it did not apply to nursing homes! The local inspectorate for nursing homes advised me that they did not question the professional judgement of a doctor. As for the doctor, he told me that he had prescribed that my mother be given a mild sedative daily for life, but only because nursing home staff had asked for it: he himself did not consider it necessary. So much for professional judgement! (The British National Formulary advises that medicines should be prescribed only when they are necessary.)

In 1998 the Mental Welfare Commission issued a document on restraint. I was concerned when I discovered that this guidance condoned the disguised administration of drugs as a form of restraint in nursing homes. When I took this up with the Commission it was acknowledged that this might be contrary to the guidance given in "A guide to consent..." It justified its position by observing that (at the time of writing) treatment could not be given under the Mental Health Act to a nursing home resident. That situation has now changed. As a result of the implementation of the 2003 Mental Health Act, treatment can now be given under mental health legislation to a resident in a nursing home, or indeed, to someone in the community. If a regulation specified that unwanted psychotropic medication could only be given to an adult under the 2003 Mental Health Act then there would be fewer people receiving unnecessary antipsychotic drugs or similar.

It has been claimed that the National Care Standards and the Care Commission provide adequate safeguards against unnecessary drugs being concealed in the food or drink of vulnerable adults. This is clearly not the case for several reasons, one being that this practice does not occur only in services regulated by the Care Commission. Another reason is that

"Unlike the national Standards in England, the National Care Standards (in Scotland) are not minimum standards but aspirational".

(Letter from Lewis Macdonald, Deputy Health Minister, to Nicol Stephen, MSP, dated 20 September 2005.)

It seems that, where standards relating to medication are concerned, Care Commission inspectors do little more than their predecessors did in the past. This was suggested by the letter from Frank McAvety to which reference was made above. There was stronger evidence that this might be the case when the Care Commission investigated a complaint about the way in which medication had been administered to a nursing home resident who died only 18 days after admission to the home. The home was absolved from all blame on the grounds that there was evidence to confirm that the drugs were all given on the written authority of a GP. In spite of requests to examine whether there had been compliance with care standards relating to medication of the Care Commission declined to do this until instructed to do so by the Ombudsman. A second Care Commission investigation then led to the death being referred to the police. The police have subsequently carried out investigations as instructed by the Procurator Fiscal's office and this might lead to a Fatal Accident Inquiry. On the basis of this case, the Care Commission does not seem to have been doing enough to protect care home residents by enforcing some important care standards.

It might be supposed that the implementation of the Adults with Incapacity Act might provide considerable protection to vulnerable adults as far as medical treatment is concerned. No such assumption should be made. Just as not all doctors and not all nursing home staff observed the law concerning consent as set out in "A guide to consent..." not all doctors and not all those acting under their instructions will observe the provisions of the Adults with Incapacity Act. Further, although it is claimed in the National Care Standards that this Act provides a legal basis for medication to be administered surreptitiously, it is not certain that this is the case.

In previous papers I drew attention to findings which make clear that safeguards are required with respect to covert medication. In particular, attention was drawn to findings that:

- more deaths are caused by avoidable adverse drug reactions that by road accidents;
- elderly people are particularly susceptible to adverse drug reactions;
- many care home residents are prescribed unnecessary drugs;
- when the unnecessary drugs are withdrawn the death rate falls.

Petition 867; W. Hunter Watson, April 2006
Since the production of my earlier papers more relevant information has come to light including the following:

- (as noted above) there has been an increase in the number of fatalities linked to the use of antipsychotics, drugs often used as a chemical restraint;
- the action of a drug can be changed if tablets are crushed so that the drug can be concealed in food or drink;
- many elderly people in care homes in England are being given the wrong medicine, someone else's medicine or doses that are dangerous; (Commission for Social Care Inspection report, February, 2006)
- a hospital patient "collapsed in agony" and died after being given medicine meant for another patient: (Daily Express, 13 February 2006)

The errors in the administration of medication that have been detected in care homes in England could also be occurring in Scottish care homes, especially in those where there is a high staff turnover or where medication is administered by care assistants rather than by nurses.

Much needs to be done to protect care home residents from medication errors. One action that should be considered is to make it clear that medication should never be administered surreptitiously in care homes for older people. That action would at least go some way towards reassuring present and future care home residents that food and drink in care homes will not contain unwanted drugs. As things are at present, even a competent resident could have drugs concealed in his or her food or drink.

The fact seems to be that only a minority of care homes do conceal drugs in the food or drink of residents. Data obtained under the Freedom of Information Act revealed that out of a sample of 100 homes only 14 had been doing this. The data was obtained from Pre-Inspection Returns held by the Care Commission.

If covert medication were ended in all care homes for the elderly it need not follow that some residents might fall to receive essential treatment. Not only could necessary powers be granted under either the 2003 Mental Health Act or Part 6 of the Adults with Incapacity Act; in an emergency, treatment could be given to an adult with incapacity or to anyone who was unconscious.

Although there now seems to be a strong case for ending covert medication in care homes for older people it may be that, if properly regulated, it could be lawful in other settings and, on balance, advantageous to the adults concerned. If after a careful examination it is concluded that this is the case then a working group should be set up to devise a suitable regulation. It has been suggested that a requirement to report any instance of covert medication to the Mental Welfare Commission might suffice. Such a limited regulation, however, would provide no protection against a potentially serious prescribing error. To afford real protection a regulation must specify conditions to be fulfilled before an unwanted drug is administered to an adult. For some this could literally be a matter of life or death.

Principal recommendations

1. Legal advice should be sought in order to determine whether surreptitious medication is compatible with the Human Rights Act.
2. If legal advice is that, in certain circumstances, surreptitious medication could be compatible with the Human Rights Act then a working group should be established to devise a regulation which would afford protection to the adults in question.
3. After taking due account of the recommendations made by the working group, the Scottish Ministers should make a regulation which would specify the circumstances in which medication could be administered surreptitiously.
4. Surreptitious medication should not be permitted in care homes for older people.
5. The National Care Standards should be amended, especially the one concerning surreptitious medication.
6. The Care Commission should be required to enforce the National Care Standards.
Public Petitions Committee – a template for public petitions

Should you wish to submit a public petition for consideration by the Public Petitions Committee please complete the template below. Please refer to the Guidance on submission of public petitions for advice on issues of admissibility before completing the template. You may also seek advice from the Clerk to the Committee whose contact details can be found at the end of this form.

Details of principal petitioner:
Please enter the name of person and organisation raising the petition, including a contact address where correspondence should be sent to, email address and phone number if available

Mr James Kelly
The Helen Kelly Campaign

Text of petition:
The petition should clearly state what action the petitioner wishes the Parliament to take in no more than 5 lines of text, e.g.

The petitioner requests that the Scottish Parliament considers and debates the implications of the proposed Agenda for Change legislation for Speech and Language Therapy Services and service users within the NHS

The petitioner requests that the Scottish Parliament......

Petition by James Kelly calling on the Scottish Parliament to consider and debate the need for an independent body to be set up within Scotland to investigate claims of medical negligence.

Additional information:
Any additional information in relation to your petition, including reasons why the action requested is necessary, should not be included here. However, it may be appended to the petition and will be made available to the Public Petitions Committee prior to its consideration of your petition. Please note that you should limit the amount of any additional information which you may wish to provide in support of your petition to no more than 4 sides of A4.
Action taken to resolve issues of concern before submitting the petition:

Before submitting a petition to the Parliament, petitioners are expected to have made an attempt to resolve their issues of concern by, for example, making representations to the Scottish Executive or seeking the assistance of locally elected representatives, such as councillors, MSPs and MPs. Please enter details of those approached below and append copies of relevant correspondence, which will be made available to the Public Petitions Committee prior to its consideration of your petition.

<table>
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<tr>
<th>Allaw Wilson MSP</th>
<th>Hugh Henry MSP</th>
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<td>Shona Robison MSP</td>
<td>Mr Blair MP</td>
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<td>Carolyn Leckie MSP</td>
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<td>Annabel M Goldie MSP</td>
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<td>Malcolm Chisholm MSP</td>
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Request to speak:

Petitioners may request to appear before the Public Petitions Committee in support of their petition, although it should be noted that requests to speak will only be granted if the Convener considers that a brief statement from the petitioner would be useful in facilitating the Committee's consideration of the petition. Due to the large volume of petitions being considered the Committee will usually only hear presentations on up to 4 new petitions at each meeting.

Please indicate below whether you wish to request to make a brief statement before the Committee when it comes to consider your petition.

Yes /  

*Delete as appropriate

Signature of principal petitioner:

When satisfied that your petition meets all the criteria outlined in the Guidance on submission of public petitions, the principal petitioner should sign and date the form in the box below. Other signatures gathered should be appended to this form.

Signature:

Date ……1.8.505.................................................................

Please note that any additional information, copies of relevant correspondence and additional signatures should be appended to this form and submitted to:

The Clerk to the Public Petitions Committee,
The Scottish Parliament,
Edinburgh
EH99 1SP
Tel: 0131 348 5186 Fax: 0131 348 5088
e-mail: petitions@scottish.parliament.uk
Dear Michael

Thank you for your letter dated 7 March 2006 concerning Petition PE866. This petition asks for an independent body to be established in Scotland to consider claims of medical negligence. I have examined this issue and reviewed the information that you enclosed.

You will recall in my reply to you of 9 November 2005 that I did not consider that a separate body to investigate claims of medical negligence in Scotland was required. I continue to hold that position for the reasons set out below.

Firstly, a number of the responses from the organisations that you consulted are against or note the difficulties in establishing such a body. Specifically the comments from the Royal College of Physicians of Edinburgh (RCPE), the Royal College of Physicians and Surgeons of Glasgow (RCPSG) and the difficulties highlighted by the Law Society of Scotland are relevant. The RCPE echoed the final point to the Committee that I made in my response to you by noting:

'The College is not convinced there would be benefit in establishing a completely independent body to investigate medical negligence. It would replicate the roles of several existing investigatory bodies, would undoubtedly be costly to administer and may be no quicker at reaching conclusions.'

It should also be noted that the Scottish Public Services Ombudsman (Ombudsman) has the powers to examine cases of medical negligence under the Scottish Public Services Ombudsman Act 2002. The Ombudsman is independent of the NHS and of Ministers and can therefore report in a wholly impartial way.
In addition there are a number of other avenues that an individual can take in having issues of medical negligence investigated including the General Medical Council, or the relevant regulatory body of the profession involved. The individual also has of course a recourse to the legal system if they so choose.

One of your respondents was Citizens Advice Scotland and it is worth noting that they are now delivering a service to the NHS to provide advice and support to patients wishing to make a complaint or raise concerns about NHS services. The organisation also provides information and advice to patients on a variety of issues that impact on their health or well-being. This Independent Advice and Support Service is now being established across Scotland. This development supports the new NHS complaints procedure which is faster and introduces independent scrutiny in the shape of the Ombudsman at an earlier stage. The emphasis is to tackle issues before they become problems. However, where mistakes occur lessons can be learned quickly.

Some of the replies that you enclosed referred to a 'no fault compensation' scheme. In March 2003 an Expert Group, established by the Scottish Executive and drawing membership from Health Boards, the Scottish Haemophilia Group Forum, the Royal College of Nursing, the BMA and Action for Victims of Medical Accidents and others, found several difficulties regarding no fault compensation. These included the scope of coverage and establishing fault and eligibility, and the potential cost, which could be substantially more than under current arrangements. Also, no fault compensation schemes tend to place emphasis on compensation rather than scrutinising accountability and discouraging/preventing future incidents by learning lessons within the NHS. The Expert Group report can be accessed at http://www.scotland.gov.uk/library5/finance/egfs.pdf

To summarise, I do not feel that it would be helpful or efficient to establish a new body to consider claims of medical negligence. This body would duplicate the work already being done by NHS Boards themselves, the Scottish Public Services Ombudsmar, the General Medical Council and ultimately the Scottish Courts. The NHS complaints procedure has been streamlined and now incorporates an advice service that is based on a wealth of experience in advising people on their rights and options for action.

I hope these comments are helpful.

ANDY KERR
Dr James Johnston  
Clerk to the Public Petitions Committee  
The Scottish Parliament  
Parliamentary Headquarters  
EDINBURGH  
EH99 1SP

28th March 2006

Dear Dr Johnston

Ref: Petition PE866

The Helen Kelly Campaign would like to thank the Public Petitions Committee for presenting us with the opportunity to respond to, The Royal College of Physicians & Surgeons of Glasgow, The Royal College of Physicians & Surgeons of Edinburgh, BMA Scotland, The Law Society of Scotland, Citizens Advice and the Scottish Executive in their responses to petition PE866.

Petition PE866 was calling for the Public Petitions Committee to consider and debate the need for an independent body to be setup within Scotland to investigate claims of medical negligence. We put it to the Public Petitions Committee that we believed that medical negligence is predominantly a working-class issue, and also, claims of medical negligence are not being properly investigated.

We have noticed within the correspondence received that a no-fault compensation has been mentioned (whether negligence is proven or not), we believe that the Public Petitions Committee should not consider this particular solution, because, Petition 866 is not about compensation. It is about the right to justice regardless of race, creed, colour, religion, nationality or social standing.

It has also been stated that, there is a national and well established mechanism in the NHS, for patients and others to raise complaints, such as the Complaints Procedure and the General Medical Council.

The Complaints Procedure

The current NHS complaints procedure reflects a culture, which does not fully value the voice of the patient. It encourages a culture of defensiveness and closed ranks. The main causes of dissatisfaction among complainants are operational failures; unhelpful, aggressive or arrogant attitudes of staff, poor communications and a lack of information and support. The most important structural failure is the perceived lack of independence in the convening decision and in the review process generally. 75% of the people using the
complaints procedure believe that it is unfair, biased, stressful or distressing.

The views of NHS staff who have been the subject of complaints are in marked contrast to those of complainants. "A majority of staff thought that the complaints against them had been handled well and they were generally satisfied with the outcome. Staff were well supported by professional and managerial colleagues and the majority thought that the process was both fair and unbiased".

The above information was taking from the Scottish Executive's, Reforming the NHS Complaints Procedure.

**The General Medical Council**

Patients have the right to direct complainants to the General Medical Council, but once again we are faced with the same scenario as the complaints procedure, closed shop, we would like to draw your attention to the following.

In a letter sent by Dean Janet Smith, Head of the Shipman Inquiry, to the Rt. Hon. John Reid MP, Rt. Hon. David Blunkett MP.

Letter dated 29th November 2004, Dame Janet Smith goes on to say, "The GMC has also introduced changes. It has reformed its fitness to practice procedures and, in many respects, the changes will result in improvement. However, for reasons too complex to set out in this letter, I am by no means convinced that the new GMC procedures will adequately protect patients from dysfunctional or under-performing doctors. I have made a large number of recommendations that would, in my view, improve the position. However, I have concluded that there has not yet been the change of culture within the GMC that will ensure that patient protection is given the priority it deserves. I have been driven to the conclusion that this is because the GMC is effectively controlled by members elected by doctors. Many of these issues which the GMC has to consider gives rise to a conflict between the interests of the professional and the public interest. Many members of the profession expect the GMC to represent it rather than to regulate it in the public interest. One of my recommendations is that the number of members appointed against 'public interest' criteria should be increased so that members elected by the medical profession no longer have the overall majority".

The Petitions Committee will see from the correspondence from RCPE letter, Ref: **General Medical Council**: where it state's that: "It should be remembered that all committees and panels include lay members, that 40% of the GMC board are lay members".

But if the Public Petitions Committee examine the Shipman Inquiry Report, you will see that during the hearing, leading Counsel for the Tamesside Families Support Group (TFSG) drew attention to the fact that a significant number of lay members **had professional background in NHS Management or Administration**, it was suggested that there were not really lay persons who could represent and safeguard the interests of the general public and of patients in particular. As a result of their professional
backgrounds, they would be steeped in the culture of the medical profession.

There where also concerns about the General Medical Councils ability to regulate the medical profession in the interests of patients, when it was discovered that senior General Medical Council officials knew of serious concerns about the paediatrician, Professor Sir Roy Meadow, the General Medical Council had discussed a series of complaints against Sir Roy Meadow in February 2000.

When courageous Dr R. Pal broke ranks to go public and highlight a string of alleged patient abuses, did the GMC protect her "No" they tried to say she was insane. R.Pal v GMC. What Judge Harris said about the GMC. "It (the GMC) is like a totalitarian regime: anybody who criticises it is said to be prima facie mentally ill - what used to happen in Russia".

Is Medical Negligence a Working-Class Issue?

We feel that the Public Petitions Committee must agree with The Helen Kelly Campaign that medical negligence is a working-class problem. The Law Society of Scotland claim that many victims of medical accidents are "children, the elderly and people on benefits". The Helen Kelly Campaign believe that the Public Petitions Committee have a duty to the people of Scotland, to bring this to the attention of the Scottish Parliament in order to stop this discrimination.

Are Claims of Medical Negligence Properly Investigated?

The Public Petitions Committee have before them the letter from the Law Society of Scotland, the Law Society of Scotland claim that "A survey carried out on behalf of the Law Society of Scotland demonstrates that the cost of time for a solicitor is substantially more than legal aid rates" "legal aid rates remain at a low level".

The Public Petitions Committee must agree that if legal aid rates are low then the standard of service must be the same. So we, the victims, are faced with a major problem of being represented by a solicitor, who cannot recover his/her costs.

The current chief executive of AvAM has said, excessive legal aid red tape in Scotland was part of the problem. "It is a disgrace that there is a lack of justice for so many Scottish patients".

But why is there a lack of justice? Is it because solicitors are faced with two major problems: 1. Not being able recover their costs from people who depend on legal aid. 2. That proving medical negligence is very difficult.

Many people have contacted The Helen Kelly Campaign and it seems we all share the same view that, "unless you have money solicitors are not interested" so is justice only for those who can afford it?
The Helen Kelly Campaign receives many e-mails supporting our campaign for justice, but one particular person had this to say:

"As I said before I saw a solicitor, but have had no real glint of hope, he (solicitor)suggested I just forget about it and get one with my life, as I would find it so difficult to prove the hospital where negligent" "it would cost me my house at least".

We can not reveal the persons real name in case of repercussions, but we can refer to the person as NURSE x.

We would like to bring the Public Petitions Committee's attention to where The Law Society of Scotland refer to the "negligence test"" In order to satisfy the negligence test, it is necessary for the claimant to prove what the standard procedure was in relation to their treatment and care and that there was a departure from the standard procedure. Only a doctor practicing within the particular speciality concerned can provide appropriate evidence as to the standard procedure.

But standard procedures can be found within medical literature.

The Scottish Parliament have standard procedures which MSP's are required to follow, for example, if a member of the public made a complaint to the Scottish Parliament and claimed that MSP's cannot represent people from other constituencies, the Scottish Parliament would refer to,

Code of Conduct for MSPs,
Relationships between MSPs,
Guidance from the Presiding Officer.
Key Principles. 4. V. "No MSP should deal with a matter relating to a constituent, constituency case or constituency issue out with his or her constituency or region (as the case may be) unless by prior agreement".

The Scottish Parliament would then contact the claimant and inform them that their claim is incorrect, and produce a copy of the above article.

But we have medical experts who are only giving opinions, there is no evidence being provided of what the standard procedures are. We have also medical expert’s who claim that they are being open and honest, but open and honest people do not refuse to answer specific questions.

Example;

The medical expert was asked, could Mrs. Kelly’s fatal haemorrhage been caused by the stress of having to be up and about on Monday morning getting prepared for her doctor’s appointment.

Medical experts reply.

"If the patient feels well enough, I will always allow them to get up,
going to the toilet, bathe, dress themselves etc".

As you will see "if the patient feels well enough", this statement from the medical expert means, that it is the patient who is informing the doctor "I feel well enough to get up", but the truth is, Mrs.Kelly was never given the opportunity to tell this medical expert anything.

We then asked the medical expert, but what if the patient was not well enough to be up and about, could this cause a fatal haemorrhage?

Medical experts reply.

"No reply"

Yes, the medical expert who is open and honest refused to answer the question. So medical experts can say and do as they please because, no one is willing to challenge the medical expert, especially those (solicitors) who can't recover their costs, is this the kind of abuse that we the victims have to accept?

We have received a report from a neurosurgeon who works within the Southern General Hospital Neurosurgical Unit who claims.

"If Mrs. Kelly had been admitted to the neurosurgical units on Sunday, no investigation would have been planned until the following morning" and "even if an angiogram had been performed on Sunday, and the angiogram showed an aneurysm (subarachnoid haemorrhage) that was treatable, the treatment would not have been undertaken until Monday at the earliest"

The Public Petitions Committee should examine medical literature on subarachnoid haemorrhage because, you will come across such things as;
1. A subarachnoid haemorrhage is an emergency and the patient must be taken to hospital immediately.
2. Patients with subarachnoid haemorrhage should have rapid access to appropriate specialist care.
3. Patients with subarachnoid haemorrhage should be kept under close observation as there is a risk that more bleeding may occur.
4. Treatment must start immediately.

These are just some of the things which we have taken from medical literature.

We also received a letter from the Southern General Glasgow NHS Trust which states,

"The Institute of Neurological Sciences has, and has always had, the capability of providing an emergency service at all times every day of the year, including investigation and treatment all of subarachnoid haemorrhage. Occasionally this means carrying out an angiogram or operating on an aneurysm patient out-of-hours. Almost always this would be for a patient deteriorating with an immediately life-threatening
haematoma, i.e. a true emergency"

We would like to ask the Public Petitions Committee to investigate why we are being denied the right to justice, when we have a consultant neurosurgeon who states, "I do not believe that if Mrs. Kelly had been admitted to Crosshouse Hospital on Saturday evening and had her blood pressure reduced that this would necessarily have stopped the fatal re-bleed on Monday morning. The only treatment which could have prevented this from happening with any certainty would be coiling or clipping of her aneurysm prior to 0900hrs on the Monday".

So when you consider that Mrs. Kelly could have been transferred to the Southern General 24hr Neurosurgical Units on Saturday evening or Sunday morning, then she could have received emergency treatment prior to her fatal bleed.

We believe that the above does indeed demonstrate that there is a need for an independent body to be setup within Scotland as too many people are dissatisfied with the present system and the system must be changed.

The RCPE have stated they are not convinced it would be benefit in establishing a complete independence body, it would replicate the role of several existing investigatory bodies, but we don't want to replicate the existing bodies because, the reason we are here is because of the failures of the existing bodies.

The Helen Kelly Campaign believes that, the Public Petition Committee should bring the representatives of The Royal College of Physicians & Surgeons of Glasgow, The Royal College of Physicians & Surgeons of Edinburgh, BMA Scotland, The Law Society of Scotland, Citizens Advice, Scottish Executive and The Helen Kelly Campaign together around one table. We believe this petition has exposed the inherent weaknesses and injustices in the current system and it would provide the people of Scotland with a unique opportunity and platform to debate Petition 866. The victims of medical negligence and the people of Scotland do not deserve anything less.

Yours sincerely,

James Kelly
The Scottish Parliament

PUBLIC PETITIONS COMMITTEE

8th Meeting, 2006 (Session 2)

Wednesday 3 May 2006


The Committee is invited to consider and agree to the publication of the attached draft annual report.

Committee Clerk
April 2006

The Committee reports to the Parliament as follows—

Introduction

1. This Report covers the work of the Public Petitions Committee during the Parliamentary year from 7 May 2005 to 6 May 2006. The Committee welcomes the continued positive feedback which it has received from many petitioners as illustrated by this comment: ‘The system of petitions to Parliament is an excellent method for members of the public to exercise the right to have their say on important issues.’

Petitions considered

2. During the period of this report the Committee considered 122 new petitions and heard oral evidence from 51 of these petitioners. In terms of the subject matter of petitions, 21 related to health and community care while 12 related to planning matters. Other recurring themes were education issues with 6 petitions relating to school provision and especially school closures and 6 petitions relating to bridge tolls. Common good assets also emerged as a salient issue for the Committee.

3. As in previous years, the Committee can identify a number of petitions which continue to illustrate the effectiveness of the system:

   - **PE786** In response to this petition from the Scottish Burned Children’s Club, the Scottish Building Standards Agency has agreed changes to regulations from 1 May 2006 aimed at preventing children being scalded from hot water.

   - **PE882** The petitioner who submitted this e-petition wrote to the Clerk stating: ‘The response to the e-petition calling for the establishment of a direct link flight between Stornoway and Aberdeen has been highly successful, with nearly 1500 signatures in the first two weeks online.’ While the e-petition was “live” Eastern Airways (UK) Limited agreed to launch such a service.

   - **PE798** The petitioner responding to the Committee stated: ‘Thank you very much for sending the responses from the Ministers regarding our Petition. We are very heartened with progress so far – in particular the interim funding as promised, as well as the steps which have been taken to carry out an independent National Review of Wheelchair Services.’
Committee Events

4. The Committee continues to actively promote the public petitions system and has held two further events in its rolling programme aimed at providing practical advice and guidance on petitioning the Parliament. The first event was held in Ayr in June 2005 and the second event was held in Dunfermline in January 2006. Both events included formal meetings of the Committee at which a number of local petitioners were invited to give evidence.

5. The Committee acknowledges from the feedback at these events that there continues to be a need to publicise the petitions system. For example, one petitioner stated: 'I was only aware that I could raise a petition after visiting the website. Perhaps more public awareness through press, leaflets etc.' One suggestion that the Committee has taken up is to produce an educational DVD, *Petitioning the Scottish Parliament*, which was launched in December 2005 and is available from the clerks.

E-petitioning

6. 41 e-petitions have been submitted over the period of this report, a number of which are still active, attracting over 22,000 signatures.

7. The Committee also welcomes the continued global interest in the e-petitions system and notes that the German Bundestag launched a pilot of e-petitioner on 1 September 2005. The system has also been awarded an eGovernment good practice label and was selected as a finalist for an eEurope award on eGovernment. The Committee was invited to exhibit the system at the Ministerial Conference in Manchester on 24-25 November 2005 and made the final shortlist of 4 nominees from over 100 submissions.

Equality issues

8. The Committee continues to mainstream equality and will shortly publish its annual equalities report based on statistics collated from equal opportunities monitoring forms which all petitioners are asked to complete. The Committee also continues to target equality groups in organising committee events. The Committee also provided BSL interpretation services at two of its meetings in this parliamentary period.

Inquiries and Reports

9. The Committee published no reports during this parliamentary period.
Bills and Subordinate legislation

10. The Committee did not deal with any bills or subordinate legislation during the year.

Meetings

11. The Committee met 20 times from 7 May 2005 to 6 May 2006. All of these meetings were held in public with only 1 item being held in private for the purpose of considering a claim for witness expenses. In addition to meeting in Edinburgh, the Committee also met in Ayr and Dunfermline.