Assisted Suicide (Scotland) Bill

The Law Society of Scotland

Introduction
The Law Society of Scotland (the Society) aims to lead and support a successful and respected Scottish legal profession. Not only do we act in the interest of solicitor members but we also have a clear responsibility to work in the public interest. That is why we actively engage and seek to assist in the legislative and public policy decision making processes.

To help us do this, we use our various Society committees which are made up of solicitors and non-solicitors and ensure we benefit from knowledge and expertise from both within and outwith the solicitor profession.

The Society welcomes the opportunity to consider and respond to the Health and Sports Committee and the Justice Committee’s call for written evidence on the Assisted Suicide (Scotland) Bill.

We recognise that the subject matter of the Bill raises moral and ethical questions and will undoubtedly prompt much public and parliamentary discussion. We are not in a position, nor would it be appropriate for us, to comment on the ethical and moral aspects of the Bill. We therefore focus our comments on the practical and legal aspects and points, raising these to promote further consideration and debate on what is undoubtedly and understandably a recognised controversial subject.

We note that the Assisted Dying Bill [HL] (England and Wales) was introduced in the House of Lords on the 15 May 20131, and is expected to receive its second reading shortly. The Assisted Dying Bill [HL] and the Assisted Suicide (Scotland) Bill share a common objective, which is to remove criminal liability from those who assist others with a terminal illness to end their own lives providing the process as set out in each respective Bill is followed. Although the two Bills share a common objective, and the process as set out within the Bills is broadly the same, there are a number of differences which we refer to in our response from a comparative perspective. One important aspect to note is that under the Assisted Dying Bill [HL] the person providing the assistance must be the attending doctor, registered medical practitioner or registered nurse. However, under the Assisted Suicide (Scotland) Bill the person providing assistance (the facilitator) can be any person 16 years and over.

Assisted Suicide (Scotland) Bill: General comments
Compliance with Article 2 European Convention of Human Rights.

We note that the Bill seeks to allow people with terminal or life-shortening illnesses or progressive conditions which are terminal or life-shortening to seek and obtain assistance from another person (a licensed facilitator) to end their life. The Bill removes criminal and civil liability from the licensed facilitator

1Assisted Dying Bill [HL] ; http://services.parliament.uk/bills/2013-14/assisteddying/documents.html
providing the provisions of the Bill are adhered to and the conditions fulfilled. Its plain effect is to allow people to assist others in taking their own lives.

At the outset, consideration needs to be given as to whether the Bill itself is competent under the Scotland Act 1998. Section 57 of the 1998 Act prohibits any member of the Scottish Executive from making any legislation which is incompatible with Convention rights. Furthermore, section 29 of the 1998 Act prevents any Act of the Scottish Parliament becoming law if it is outside of the legislative competence of the Parliament. An act will be outside of competence if ‘it is incompatible with any of the Convention rights …’

The Bill therefore, may be in direct contrast, and possibly incompatible, with Article 2 of the European Convention on Human Rights, which protects the right to life.

The role of a solicitor as a ‘proxy’
The role of solicitors as currently described in the Bill gives rise to uncertainties. The inclusion of solicitors in the Bill may not be appropriate in the particular circumstances. Specifically, the provision in section 16 of the Bill providing for solicitors to act as proxies for a person may be better implemented by a medical practitioner.

Section 16, which directly impacts on solicitors, identifies specific categories of individuals as proxies who may sign a document on behalf of a person who is blind, unable to read or unable to sign his or her own name. We note that section 16 is derived in substantial form from section 9 of the Requirements of Writing Act 1995 (1995 Act).

Section 16 (6) provides that a proxy means (amongst others) ‘… a solicitor who has in force a practising certificate as defined in section 4(c) of the Solicitors (Scotland) Act 1980 (c.46) …’ We have a number of concerns relating to including solicitors in this role. We are of the view that solicitors should not undertake this proxy function.

It is noted that the Assisted Dying [HL] Bill, make no such provisions. It would be useful to understand the intention behind section 16 of the Assisted Suicide (Scotland) Bill. Is there statistical evidence to indicate that the use of a proxy has been identified as a real need? We further note that the Assisted Dying [HL] Bill does not account for such a situation. The Assisted Dying [HL] Bill centres responsibility on the registered medical practitioner and makes an assumption that a person can physically make a declaration. This may be a

2 Scotland Act 1998 Section 57(2) ‘A member of the Scottish Executive has no power to make any subordinate legislation or to do any other act, so far as the legislation or act is incompatible with any of the Convention rights or with [EU] law’
3 Ibid Section 29(2)(d)
4 European Convention on Human Rights Article 2 ‘Everyone’s right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law’
5 Requirements of Writing Act 1995 S9 Subscription on behalf of blind granter or granter unable to write http://www.legislation.gov.uk/ukpga/1995/7/section/9 The 1995 Act repealed in its entirety section 18 of the Conveyancing Scotland Act 1924 relating to notarial execution.
weakness in the Assisted Dying [HL] Bill and is in clear contrast to the Assisted Suicide (Scotland) Bill.

It is assumed that the reference to the specific categories (solicitors, advocates and Justice of the Peace) in section 16 is there simply because they mirror section 9 of the 1995 Act. In the alternative, it may also be on account of these individuals being recognised “professionals” of “good standing” or “moral character”. However, given that the duties required of the professionals under the Bill are not the same as intended and anticipated under the 1995 Act, we suggest that it is therefore not appropriate for solicitors to carry out this function.

It may be more appropriate for this function to be performed by individuals other than the professionals identified in the Bill. With reference to comparative law, under Belgian legislation6 a person who is permanently incapable of signing a directive can designate a person ‘…who is of age and who has no material interest in the death of the person in question, to draft the request in writing…’ provided that there are two witnesses present (of age with no material interest) and the directive explains why the person is incompetent to sign together with a medical certificate. The Act therefore anticipates the possibility of requiring a proxy but does not require the proxy to be a lawyer. In the Netherlands’ legislation7 there is no comparative guidance regarding what can happen where a patient has capacity, but requires a proxy to physically sign a directive on their behalf.

On the face of it, we would suggest that the Belgian model appears to offer a more secure process by providing checks without the direction to employ a particular professional. Notably Belgium does not require an assessment that the person understands the effect of the document by the proxy.

Our concern with section 16 is that this requires a solicitor to perform more than a ’notarial’ execution. This is because section 16(4) requires the proxy to reach a judgment about the person’s understanding of the effect of the document.

While section 16 envisages a physical or other limitation preventing a person from subscribing a document, in fact, the requirement of section 16(4) obliges a solicitor to make an assessment about mental capacity too. We question if all solicitors will be appropriately qualified or experienced to make this decision.

Making a decision about capacity also necessitates a consideration of vulnerability.

Law Society of Scotland Guidance provides that ‘...The possibility of vulnerability should be considered whenever a solicitor is consulted or instructed in any matter. Often the solicitor will be able to decide quickly and

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6 Belgian Act of Euthanasia 2002, Chapter III, section 4 (1)
7 Termination of Life and Assisted Suicide Act 2002
confidently that there is no question of vulnerability; but solicitors should always be alert to any indications of possible vulnerability…'

Furthermore the Law Society of Scotland Practice Rules 2011 state that a solicitor ‘…must only act in those matters where you are competent to do so…’ (Rule B 1.10)8. However solicitors must not discriminate contrary to Rule B 1.15.1. They may accordingly require referring to another solicitor, whose particular skills are required in determining capacity, identifying vulnerability, or in advising and acting for a particular client.

Indications of possible vulnerability may arise from the normal process of ascertaining a client's wishes and intentions, exploring circumstances, and advising as to merits, risks, advantages and disadvantages of a proposed act or transaction, or of alternatives. However, on the one hand an apparently unwise act or transaction may represent a client's valid and competent choice; while conversely an apparently wise act or transaction could be invalid through lack of relevant capacity, or undue influence, or other vitiating factors.

We believe that the nature of assisted suicide makes the considerations highlighted above relevant.

Society Guidance in relation to vulnerable clients also advises that a ‘…solicitor should not simply rely upon the legal presumption of capacity. On the contrary, they "must …. be satisfied when taking instructions, that his or her client has the capacity to give instructions in relation to that matter…'9 (guidance related to Rule B 1.5). In cases of doubt as to the extent to which, and circumstances in which, capacity can be exercised, or conversely as to the extent to which incapacity prevents a contemplated act or transaction, the advice of a medical practitioner or clinical psychologist should be sought. It may be necessary to approach someone with particular specialist expertise. The solicitor should not seek a generalised and simplistic verdict of "capable" or "incapable". The solicitor should explain the act or transaction contemplated and the legal requirements for it to be valid. The solicitor should explain any indications of relevant capacity or incapacity of which the solicitor is aware, and any steps which the solicitor proposes.

Solicitors have a duty to assess capacity in relation to all of their clients regardless of area of law or what the client is contemplating. If a solicitor is not experienced enough or is without the skill or knowledge to be able to assess a person’s capacity properly then the solicitor should seek further advice. In normal circumstances, such advice would be sought from a medical practitioner. The guidance demonstrates that where a client with capacity instructs a solicitor to do something which the solicitor has advised against or considers to be unwise, then it is not the responsibility of the solicitor to


prevent the client from making bad decisions. For example, in a conveyancing transaction where a client instructs a solicitor to sell a house at a value considerably less than the asking price then, provided that he was satisfied the client was clear on what he wanted to do and had assessed the risks, it is not for the solicitor to protect the client from himself. This can be contrasted with the position of assisted suicide where the outcome and impact of a decision is far more significant than money you would receive for selling a house. A decision in this context is terminal and irreversible. Conveyancing solicitors understand the property market and can give advice on what the range of options might have been for the client looking to sell the property. However, generally speaking, solicitors will not have experience or understanding of a person facing a terminal illness and seeking to die. The assessment of capacity required in a situation like that goes beyond what the ordinarily solicitor might be expected to know and be able to assess. There is such a fundamental presumption for preserving life within our society that it may be very difficult for a solicitor to know or accept that a person has capacity to make such a choice and for a solicitor to be part of that process.

Given this advice we suggest that the Bill provides for the referral to a medical practitioner or that medical practitioners are substituted as proxies given their position to be better able to assess the necessary capacity that a person requires in relation to assisted suicide over solicitors.

We note that the Assisted Dying [HL] Bill at section 8 introduces a requirement for a Code of Practice. While that Bill does not make provision for a proxy, it does recognise that those professionals who are involved in the process will be required to make an assessment of a person’s capacity. The Assisted Dying [HL] Bill recognises the significance of properly understanding capacity and the nature of this act and considers it so important so as to require a formal Code of Conduct.

Client relationship and professional duties

With some exceptions, ordinarily the act of being proxy would not give rise to a solicitor /client relationship. The position is less clear where a solicitor is expected to assess a person’s understanding of the document. In the event that acting in this capacity does establish a solicitor/client relationship a solicitor requires to exercise and give due regard to the rules of professional conduct and behaviour, recognising that his or her professional obligations are not only to their clients, but to the courts, the legal profession and the public. Amongst other things, these rules regulate:

- confidentiality and legal professional privilege
- trust and personal integrity
- the interest of the client
- independence of the solicitor
- disclosure of interest
- relations with the Courts
- conflict of Interest
These distinct duties and roles that a solicitor performs are not reflected in the Bill. If this is a solicitor/client relationship it will require clarity around terms of engagement and fees and whether the solicitor is in contract with the person. The Bill envisages the solicitor acting as proxy as performing a role akin to a public officer and not that of an advisor. However given the requirement in section 16(4) it is not clear how or whether a solicitor can limit their role to that of a “public officer” and not give regard to the professional duties as a solicitor, especially if it unclear as to whether the person is also a “client”.

Acting as proxy outwith Scotland

In line with section 9 of the 1995 Act, the Bill also makes provision for a proxy to sign a document outwith Scotland if the proxy is a notary public or has ‘…authority under the law of the place to sign or execute documents on behalf of person who are blind or unable to read or sign…’

We suggest that such a broad provision does not provide sufficient safeguards for a person seeking to implement the provisions of the Bill. Given the variety of notaries in legal jurisdictions there is no certainty that they will have capacity to ensure the person understands the effect of the document. Likewise a person with “authority under the law” is a very broad provision that could leave a person vulnerable and without any support or professional guidance.

Section 16 of the Bill also raises the question of legislative competence (as referred to above) under the Scotland Act 1998 section 29, which prevents the Scottish Parliament from introducing legislation if ‘… it would form part of the law of a country or territory other than Scotland or confer or remove functions exercisable otherwise than in or as regards Scotland…’

Section 16(6) (d) directly seeks to confer on a ‘notary public or other person with authority under the law of that place to sign or otherwise execute documents…’ the authority to act as a proxy, notwithstanding the fact that assisted suicide itself may be prohibited in that jurisdiction outwith Scotland and a notary public may be expressly prohibited from acting as a proxy.

We also note that the Bill’s Financial Memorandum anticipates that the General Medical Council and Royal Pharmaceutical Society will require to revise codes of practice and guidance to reflect the changes in the Bill. In the event that solicitors remain as proxies, advice and guidance will also be required for this professional body and the impact of this should be acknowledged and accounted for.

Responses to the call for evidence questions:

1. Do you agree with the general purpose of the Bill to make it permissible, in the circumstances provided for, to assist another to commit suicide?

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10 The Scotland Act 1998 Section 29(2) (a)
We are not in a position to comment on the general purpose of the Bill since this would involve the application of moral and ethical judgement. Our comments therefore are confined to the practical and legal application of the Bill.

2. Do you have any views on how the provisions in this Bill compare with those from the previous End of Life Assistance (Scotland) Bill?

In January 2010, the End of Life Assistance (Scotland) Bill11 was introduced with the aim to ‘enable persons whose life has become intolerable and who meet the conditions prescribed in the Bill to legally access assistance to end their life.’ It sought to achieve this by decriminalising both euthanasia and assisted suicide under the single definition of ‘end of life assistance.’

The appropriateness of treating these two concepts raised many concerns as demonstrated in the evidence presented to the ad hoc committee of the Scottish Parliament (End of Life Assistance (Scotland) Bill Committee) where it was described as ‘largely unchartered territory for any jurisdiction’12. We consider it less confusing that the current proposals include only assisted suicide.

It was noted in the previous Bill that the interpretation of its title – ‘End of Life Assistance’ may be construed in a different way. One example being the confusion over assistance to mean the provision of palliative care. The title of the Assisted Suicide (Scotland) Bill makes it quite clear that it relates to assisted suicide and therefore should be less ambiguous.

3. The Bill precludes any criminal and civil liability for those providing assistance, providing the processes and requirements set out in the Bill have been adhered to. Do you wish to make any comment on this?

The Bill does not define what assisted suicide is, or what it is to assist suicide. That will cause difficulties in interpretation. (see our comments below to Section 1)

4. The Bill outlines a three stage declaration and request process that would be required to be followed by an individual seeking assisted suicide. Do you have any comment on the process being proposed?

We consider sections 4, 5, 7 and 8 below. We do however have some general observations to make from a comparative perspective.

All of the jurisdictions which have enacted legislative provisions for assisted dying require another independent physician to confirm that whatever legal requirements have been put in place, have been met. Any declaration and request process should serve to ensure that adequate consultation has taken place, which should include the quality of that consultation in terms of information provision which explores diagnosis, prognosis, treatment and

11 http://www.scottish.parliament.uk/S3_Bills/End%20of%20Life%20Assistance%20(Scotland)%20Bill/b38s3-introd.pdf
12 http://archive.scottish.parliament.uk/s3/committees/endLifeAsstBill/reports-10/ela10-01-vol1.htm
alternatives. Importantly, given that most actions and decisions will be considered retrospectively, any process put in place should enable transparent and effective scrutiny. In the Netherlands this is effected through the ‘Due Care’ criteria which is set out in section 2(1) of the 2001 Act. The physician must know the patient sufficiently well to be able to assess whether the due care criteria has been met. A second independent physician must consult with the patient and provide a written opinion attesting to the fact that this has indeed been the case. Cases where there is no established doctor patient relationship are more likely to be investigated. The Netherlands provides a state funded programme – Support and Consultation on Euthanasia in the Netherlands (SCEN) which trains physicians to be consultants and provides support and advice for doctors treating patients at the end of life. We would suggest that further consideration be given to a similar programme should the Assisted Suicide (Scotland) Bill be enacted.

In Belgium the consulting physician must examine the patient and their medical records to ensure that their condition and experience of suffering cannot be alleviated. The physicians are required to have ‘several conversations with the patient spread out over a reasonable period of time’. In addition, if the patient is not expected to die ‘in the near future’ there is a mandatory, further consultation with either a psychiatrist or relevant specialist (and a waiting period of at least one month).

In Oregon, the attending physician must refer the patient to a ‘consulting physician for medical confirmation of the diagnosis and for determination that the patient is acting voluntarily and has the requisite capacity. The patient must be referred to a counsellor if either the attending or consulting physician suspects that the patient ‘may be suffering from a psychiatric or psychological disorder, or depression causing impaired judgement’.

The Assisted Dying Bill [HL] Bill, follows similar processes, described above, requiring at least two physicians to examine the patient with particular attention to ensure that the essential criteria has been met. It also raises issues of physician responsibility and role which have been considered by us elsewhere in this submission. The Assisted Suicide (Scotland) Bill does depart from other current legislation by setting out this process in a number of sections. Most regimes have captured these requirements within one section, which arguably makes the process a little clearer and requirements more understandable.

5. Do you have any comment on the provisions requiring that the person seeking assisted suicide must have a terminal or life-shortening illness, or a progressive condition which is either terminal or life-shortening?
See our comments below on Section 8.

6. Are you satisfied with the eligibility requirements as regards age, capacity, and connection with Scotland as set out in the Bill?

13 Death With Dignity Act 1995
Age
(see our comments below on Section(s) 4 and 8)
Capacity
We have concerns in relation to ‘capacity’ under the provision of the Bill.
(see our comments below to Section 12)

7. Do you have any comment on the roles of medical practitioners and pharmacists as provided for in the Bill?
We note that the Bill only indirectly addresses the means by which the suicide for the assisted person may be brought about. The assumption appears to be that a formulation/concoction of drugs or other pharmaceutical means will be prescribed by the general practitioner to the assisted person.

We note that the Financial Memorandum (paragraph 9) extrapolates that the average number of deaths per year in Scotland, from assisted suicide may be around 79. In 2013 there were 4,858 practising General Practitioners (GPs). The vast majority of GPs will not experience an assisted suicide request. We suggest that it is important that GPs are supported by the provision of a standardised expert generated formulary for the prescription of the drugs or other pharmaceutical means which are to be used to complete the suicide act, so as to ensure that the intended outcome is achieved as speedily, effectively and as painlessly as possible. Ad hoc prescribing cannot be an option.

8. Do you have any comment on the means by which a person would be permitted to end his/her life under the Bill?
We would suggest that, to ensure the intended outcome for the assisted person, the means (drug or other substance or means dispensed) should be the subject of a standardised expert generated formulary and that an expert panel, to include pharmacists, anaesthetists and other appropriate experts, is convened to produce a standardised formulary for the drug formulation. Consideration should also be given as to the impact of these drugs (or other pharmaceutical means) on organ donation, will the drugs or other substance used adversely damage otherwise healthy organs which will then be unsuitable for transplantation?

We would also suggest that assisted persons may vary in their physical capabilities depending on their terminal or life-shortening illness or progressive condition which is terminal or life shortening and it may not be in their physical capability to administer the means by some methods. The ‘assisted suicide’ formulary therefore should include not only alternative lethal drug formulation but also varying mechanisms and routes of administration which will enable all those assisted persons, able bodied or otherwise, to self-administer.

9. Do you have any comment on the role of licensed facilitators as provided for in the Bill?
A general function of the licensed facilitators, as described in section 19 of the Bill, includes being with the assisted person when suicide act takes place and to be responsible for the removal of the suicide drug/substance/means after the expiry of the 14 day time period referred to in section 17(2) if necessary.
The section does not address either the safe keeping aspects of the drug or other substance or means dispensed or record keeping of when and what was consumed by the assisted person and what remains, if anything, of the drug or other substance or means dispensed which requires removal and return to a pharmacist for destruction purposes – these omissions require to be addressed.
(See further comments below to section(s) 18 and 19)

Section 22 of the Bill (Licensing of facilitators) is, we would suggest, inadequate in that it fails to take into account a number of things that the regulations should also cover.
(See further comments below to section 22)

10. Do you have any comment on the role of the police as provided for in the Bill?

The investigation of deaths in Scotland is conducted by the Procurator Fiscal (PF) through the exercise of the Lord Advocate’s common law powers. As we understand, the Bill intends to regulate suicide in a medical context and to ensure death is dignified for the person committing suicide and their nearest relatives.

Current practice is, broadly speaking, where death occurs in a medical context, the death is reported to the PF by the relevant medical practitioner, rather than to the police. That is to be contrasted with the situation in which a suspicious death occurs where generally it would be reported directly to the police (who in turn will report to the PF). Recognition of the Lord Advocate’s common law duty is worth inclusion in the Bill as the police are likely to require to report the death to the PF at the conclusion of their investigation.

Whilst concepts of dignified death etc have been taken out of the Bill it is worthy of note that depending upon the record keeping etc of the licensed facilitator, there may require to be a police investigation which will be by its nature intrusive whilst the police clarify that the suicide has taken place in accordance with the principles set out in the Bill.
(See further comments below to section 20)

11. Do you have any comment to make about the Bill not already covered in your answers to the questions above?

Requests from a person outwith Scotland

We note that neither the Bill or guidance notes consider the impact, if any, that the lawfulness of assisting suicide in Scotland, may have beyond Scotland. It may be anticipated that individuals in other jurisdictions might seek to make use of the legislation, particularly if assisted suicide or euthanasia is not permitted in their own country.
(see further comments to section 8 below)

Proxies outwith Scotland

Section 16 also anticipates a notary or person “with authority under the law of that place” being able to sign any declaration by way of proxy. This is considered further in the commentary of the Bill, however it is noted that this
is an extremely broad provision and provides none of the safeguards that would apply to a proxy in Scotland under the Bill as currently drafted. Given the variety of notaries and differences among jurisdictions as to who may be “authorised” it is suggested that the opportunities for a person outwith Scotland to utilise the legislation is examined further.

Conscientious Objectors
The Bill does not provide for, nor recognise that some individuals, particularly medical or legal professionals may wish to adopt a position of “conscientious objector”. Medical practitioners may not be prepared to endorse a declaration or request. A solicitor may not be prepared to act as a proxy. We note that the Assisted Dying Bill [HL] Bill expressly provides for conscientious objectors at section 5 ‘...A person shall not be under any duty (whether by contract or arising from any statutory or other legal requirement) to participate in anything authorised by this Act to which that person has a conscientious objection...’ We suggest that consideration needs to be given to incorporate a similar provision into the Assisted Suicide (Scotland) Bill.

Schedules
More is said about the schedules in the Bill commentary below, however we note that the schedule requires a medical practitioner to sign and endorse it if they are satisfied that the requirements within the declarations have been met. The Bill does not provide what happens if a witness or medical practitioner is not satisfied. Will a medical practitioner record that he is not satisfied that, for example, the person has insufficient capacity or that the practitioner considers undue influence to have been applied - could an assessment of this nature trigger a process to ensure such individuals are protected or supported differently? It is noted that the Assisted Dying [HL] Bill does require that a medical practitioner is satisfied that the person has capacity and that they understand the other options available to them in terms of palliative care for example.

Responsibility for the process
At a practical level who, if anyone, shall be responsible for guiding a person through the process? Will this be the facilitator, who maybe be the appropriate person to provide assistance, support, comfort and assurance, but may not necessarily be familiar with the legislative provisions and process Will it be the medical practitioner who will be required to advise of all of the various stages and time periods under the Bill? It will be important for individuals to understand the assisted suicide will only be lawful if the provisions of the Bill are followed and that it is not possible to exclude any elements of the process.

Professional Standards and Obligations
The Bill gives rise to a tension by overlooking the professional obligations and standards which have already been imposed on the medical and legal professionals being asked to help in this process. There is a challenge in treating the process as a dignified, but still primarily a process driven procedure. This is because the nature of assisted suicide and the acute impact of the proposed legislation also necessitates judgment, assessment, and in many cases an element of ethical analysis by the professionals.
involved in the process. While not accounted for specifically in the Bill, these additional elements cannot be removed from the process as long as these professionals are embedded in the process.

It is this juxtaposition between process and professional judgment that creates a tension in the Bill since the professional obligations and standards that medical practitioners and solicitors require to apply are not displaced by the requirements made of them in the Bill.

Comments on the provisions of the Bill:

Part 1
Section 1: ‘No Criminal Liability for assisting suicide’
It is noteworthy that the provisions of section 1 are unusual in its terms in that it defines what is not a crime as opposed to the normal legislative provisions which generally set out what will amount to a crime.

We note that the Bill fails to define what ‘assisted suicide’ is, or what it is to assist suicide. As this is the very essence, and given the nature, of the Bill, we suggest that this must be clearly defined and set out on the face of the Bill. Failing to define this may cause difficulties in interpretation. Currently there is no crime of assisting suicide in Scotland unlike England and Wales where the Suicide Act 1961, section 214 makes it an offence to do an act capable of encouraging or assisting the suicide or attempted suicide of another person where that act is intended to encourage or assist suicide or attempted suicide.

It should be noted however, that in 2010 the Director of Public Prosecutions for England and Wales introduced a policy setting out guidelines which provides guidance to prosecutors on the public interest factors to take into account in reaching decisions in cases of encouraging or assisting suicide. The purpose of the policy is not to decriminalise or legalise assisted suicide but to allow more focus ‘…on the motivation of the suspect rather than the characteristics of the victim. The policy does not change the law on assisted suicide. It does not open the door for euthanasia. It does not override the will of Parliament. What it does is to provide a clear framework for prosecutors to decide which cases should proceed to court and which should not…’

In Scotland, a person who assists another to end their own life could be liable to investigation and prosecution under the law of homicide. However, there are no modern examples of prosecutions in Scotland which means that the absence of a definition of assisted suicide within the Bill, beyond section 18 (Nature of assistance: no euthanasia etc) which prevents anyone doing anything that in itself causes another person’s death, leaves room for uncertainty.

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14 Suicide Act 1961 S2 Criminal liability for complicity in another’s suicide.
‘A person who aids, abets, counsels or procures the suicide of another, or an attempt by another to commit suicide, shall be liable on conviction on indictment to imprisonment for a term not exceeding fourteen years.’

15 Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide
http://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.html

16 Director of Public Prosecutions, Keir Starmer QC
http://www.cps.gov.uk/publications/prosecution/assisted_suicide.html
We note that the Bill’s explanatory notes, (page 2) state that section 1(1) ‘… applies only when the substance of the case against an individual is (or would be) an assisted suicide does not apply to any incidental unlawful act which an individual may have committed (e.g. with a means used to commit suicide were unlawfully applied under legislation restricting circulation of particular items, such as drugs)…’ We understand that the intention of section 1(2) of the Bill, which makes reference to the essential safeguards in section 3, is to give effect to this policy aim.

However, given the widely framed nature of section 1(1), we suggest that it may be conceivable that it could be argued that on the face of the Bill, assistance which otherwise might be unlawful in terms of another provision or the common law may be protected due to lack of a definition of assisted suicide.

Section 3: ‘Essential safeguards’
We note that section 3 deals with essential safeguards and seeks to ensure that written evidence is recorded of ‘autonomy’ for the ‘assisted suicide’ person. We further note that section 3(c) provides that, following a second request for assistance, the person has a 14 day window within which assistance to commit suicide can be accessed. The assistance is to be provided by a ‘facilitator’, however, the Bill is silent on how the act of suicide will be brought about, although this could be inferred from reference to ‘…any drug or other substance or means dispensed or otherwise supplied…’17, we would suggest this needs to be fully defined on the face of the Bill.

As the act of suicide will be brought about by the prescription and administering of ‘drugs’ (or other substance or means dispensed) prescribed by the assisted person’s GP, the Bill does not provide for any essential safeguards (i.e. safekeeping requirements during the 14 day time period) for the secure and necessary safe storage of prescribed drugs (or other pharmaceutical products) which are to be the mechanism of suicide for the assisted person.

We note that the Assisted Dying [HL] Bill introduces greater clarity to the process and definition of “assistance” although this Bill too does not define what assistance is and where assistance becomes something more (see specifically section 4 (c)).

As the assisted person has the autonomy to decide at any time within each 24 hour cycle of the 14 day period (for example a decision may be made at 3 am) that they would like assistance with the suicide, then the prescribed suicide drugs (or other substance or means dispensed) need to be readily available. It would seem reasonable therefore that the drugs (or other pharmaceutical substances) are immediately available to and stored by the assisted person. It would seem equally reasonable that these ‘fatal dose’ drugs/substances have specific ‘safe keeping’ requirements attached to them, for example, in a

17 Assisted Suicide (Scotland) Bill Section 19 (c).
lockbox that only the assisted person has access to.

It could be argued that drugs/substances which can be fatal in overdose are currently kept in the home environment without attachment of legally enforceable safe keeping requirements; the difference with the assisted suicide drugs/substances, as opposed to drugs for the treatment of a medical condition, is that the assisted suicide drug/substance will have been designed for the very purpose of bringing about death. As a consequence, any unauthorised access and accidental ingestion (children etc) would necessarily be fatal.

By contrast the Assisted Dying Bill [HL] expressly requires that the attending doctor, registered medical practitioner or registered nurse must deliver and prepare the medicine for self-administration by the assisted person and remain with the assisted person until he or she has self-administered the medicine, died or decided not to proceed. These conditions, in our view, go some way to address concerns regarding the safeguards as discussed above.

In relation to the 14 day window within which assistance to commit suicide can be accessed, it is unclear how will this be monitored/enforced. (see our further comments on section 17).

Again, by way of contrast, there is greater certainty in this respect in the Assisted Dying [HL] Bill, where section 3(5) provides for when a person's declaration becomes effective. This is an important safeguard and important element of a structured process which the Assisted Suicide (Scotland) Bill has missed.

Section 4: ‘Preliminary declaration, witness statement and medical practitioner’s note’
In dealing with who may witness a preliminary declaration made by the assisted suicide person, section 4(2)(b) states the witness ‘...is not disqualified under schedule 4 from being the witness...’. Schedule 4 paragraph 2(g) states a disqualifying relationship for a witness to be ‘...anyone who will gain financially in the event of the (assisted) person’s death whether directly or indirectly and whether in money or money’s worth...’

This could become a live issue post assisted suicide, where the person who acted as a qualified witness was not aware at the time of the assisted suicide that they would benefit financially, directly or indirectly, as a result of the assisted person’s death.

Schedule 1, to which section 4 refers, sets out the conditions required of a person to be able to make a preliminary declaration. The condition requires the completion of a schedule declaration, the form of which is set out in schedule 1. The schedule requires a witness to the declaration. The witness must be an “acquaintance”. There is no definition of an acquaintance, but it must be someone “who has known the person but it must be longer than the

18 Assisted Dying Bill [HL] section 2(4)(5) and (6)
period associated with the signing of the declaration.” It is not clear what this means and the time period to be applied to an acquaintance. We suggest that a clear, unambiguous definition is provided to avoid uncertainty in interpretation.

We note that no element of relationship is required for a proxy to act on behalf of a person. Given the requirement for a proxy to satisfy that a person “understands the effect of the document” it might be expected that person acting as proxy has some prior contact with the person if they are expected to be able to express satisfaction that the effect of the document is understood. In the ordinary course of business a solicitor would require a degree of contact with a client in order to properly understand an instruction and in order to assess the extent to which the client has capacity or vulnerability.

A safeguard built into the Schedule is for a witness to acknowledge that they do not expect to be disqualified from acting as a witness in terms of schedule 4. In the event that a witness is, or becomes disqualified, do the provisions in section 24 rectify the position provided the witness acted in good faith or is it necessary for the procedure to be repeated with a different witness, or does it invalidate the consent? Alternatively might the provisions under section 9(4) of the Requirements of Writing Act 1995 be adapted to apply in such circumstances in order that a person relying on the document being properly executed is not denied its effect on account of the ignorance or malpractice of the witness or practitioner signing.

We also note that section 4 requires the registered medical practitioner to endorse the declaration. The explanatory notes accompanying the Bill state19 ‘…practitioner [has] to confirm that in his or her opinion the declaration and witness statement comply with the requirements of schedule 1 and that he or she has no reason to believe that they contain any false statement…’ We suggest that the practitioner will require knowing the patient and his or her background and circumstances reasonably well to be able to ascertain this.

Section 4 (and section 8) provides that the assisted person must be at least 16 years of age. In Scotland, the legal age of capacity is 16 years and a person of that age has the right to consent to, or decline, treatment (unless they lack the capacity to do so). A person under the age of 16 years can consent to, or refuse, medical treatment but only if they understand what treatment is being proposed20. It is up to the doctor to decide whether the person under 16 years of age has the maturity and intelligence to understand the nature of the treatment, the options, the risks involved and the benefits. Section 4 would appear to abrogate section 2(4) of the Age of Legal Capacity (Scotland) Act 1991 for the purposes of assisted suicide.

Given the serious and irreversible consequences of the act in contemplation

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19 Assisted Suicide (Scotland) Bill Explanatory Notes: Paragraph 13
20 Age of Legal Capacity (Scotland) Act 1991: Section 2(4) A person under the age of 16 years shall have legal capacity to consent on his own behalf to any surgical, medical or dental procedure or treatment where, in the opinion of a qualified medical practitioner attending him, he is capable of understanding the nature and possible consequences of the procedure or treatment.
careful consideration should be given to the age limit specified in the Bill. We note that the Assisted Suicide Bill [HL] expressly states that the person seeking assistance ‘...is aged 18 or over...’21 and also In England and Wales, a 16 year old’s refusal to medical treatment can be overridden if it is considered to be in his or her best interests. However, as the age of legal capacity is 16 years in Scotland the question of whether or not a 16 or 17 year old’s refusal for treatment can be overridden, by parents for example, has not come before the Scottish courts. Under the provisions of the Bill, it would be possible for a 16 year old to request assisted suicide and for another 16 year old to act as his or her licensed facilitator.

Section 5: ‘Recording of making of preliminary declaration in medical records’
Section 5 refers to the preliminary declaration and places a duty on the GP to record the declaration on the assisted person’s medical records. However, we further note that there is no obligation on a practitioner to make or retain other notes about the assisted person. For example is it anticipated that a practitioner might also make comments about the person’s capacity or physical health? Will such notes be retained in medical records or with the declarations? In the event that a practitioner has concerns about capacity or the person how is this resolved or recorded? These questions become even more relevant beyond the first stage of the preliminary declaration.

Section 7: ‘First request for assistance’
Section 7 describes the process by which a person may cancel a declaration. While there are schedules for all of the declarations, we note that there is no standard cancellation schedule. We suggest that the absence of a standardised schedule may make it more difficult to assess the validity of the document, potentially making it more difficult for a person to ensure they provide the correct information and follow the appropriate process. A cancellation also comes without the safeguards attached to the declarations like an assessment by a practitioner or a witness. We suggest that the current provision may permit a relative (who did not support a person’s decision to ask for assistance) to coerce a vulnerable person who had signed declarations to submit a cancellation since all that the cancellation notice envisages is a “notice” signed by the person and provided to the medical practitioner. It requires no witness or assessment.

We suggest, for consistency, clarity and certainty, that a cancellation also operates with a witness and medical practitioner present. Clearly the role of the practitioner would not be to prevent a person from cancelling the declaration just as it would not be to encourage a declaration to be made. However, it would allow for an assessment of capacity and judgment and perhaps indicate where other areas of support might be offered to the person.

Section 8: ‘First request for assistance’
Section 8 sets out the conditions which will apply in making the first request for assistance. This includes a provision that the person has, after reflecting on the consequences for that person of the considerations set out in section

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21 Assisted Dying Bill [HL] section 1(c) (i)
8(4) and in the light of that reflection, concluded that the quality of the person’s life is unacceptable. The considerations are that the person has an illness, or condition, that is, for the person, ‘...either terminal or life shortening...’ (section 8(5).

This implies that it is the person alone who will decide whether their illness or condition is life-shortening, although the medical practitioner will require to be satisfied that the person’s conclusion is not inconsistent with the facts known to the medical practitioner (Section 9(2)(c)). However, section 9(5) requires the medical practitioner only to confirm that the person has an illness or condition that is terminal or life-shortening (not whether it is so for the person). This is confusing and could cause difficulties with interpretation and implementation.

Mental illness is known to shorten life by 10-20 years for all major mental illnesses, not only as a result of suicide, but also as a result of physical factors such as cardiovascular disease. It can also cause very poor quality of life with no prospect of improvement for a variety of reasons: these can include:

- the symptoms themselves
- chronic unemployment
- isolation and loneliness
- the side-effects of medication
- co-morbidities such as diabetes and cardio-vascular diseases
- co-morbid substance abuse

We suggest that it may be argued therefore that mental illness fits into the criteria outlined by the Bill, i.e. shortening of life (and poor quality of life), and it would be possible to argue that it was also terminal in some cases, given that 10% of people suffering from illnesses such as schizophrenia and bipolar disorder are said to die by suicide, with a high percentage of people with chronic depression also doing so.

We note that the Bill does not exclude persons who are subject to compulsory treatment under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the 2003 Act) or the Criminal Procedure (Scotland) Act 1995 from making a request for assistance. Before a person can be made subject to a compulsory treatment order, a compulsion order or a compulsion order with a restriction order, a tribunal or a court will have to be satisfied that the statutory tests have been met for the making of the order. A person who is subject to a compulsory treatment order will have to satisfy the significantly impaired decision making (“SIDMA”) criterion (see comments on section 12) whereas those subject to a compulsion order or a compulsion order with a restriction order will not. In either case, where a patient is subject to compulsory measures they will be receiving medical treatment for their mental disorder, the features and characteristics of which may include suicidal ideation. The medical treatment must fit the statutory criterion, “that medical treatment which would be likely to

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22 See article; ‘Life expectancy gap widens between those with mental illness and general population’ http://www.bmj.com/press-releases/2013/05/21/life-expectancy-gap-widens-between-those-mental-illness-and-general-popula
(i) prevent the mental disorder from worsening; or (ii) alleviate any of the symptoms, or effects, of the disorder, is available for the patient;"  

The medical treatment may result in a reduction or removal of suicidal ideation. Accordingly, the Society is of the view that those subject to compulsory measures should be excluded from the definition of those who may make a request for assistance.

Section 12(1)(a) proposes that a person has capacity to make a request if the person is not suffering from any mental disorder - which is not defined but is assumed to include mental illness, learning disability and personality disorder which might affect the making of the request, which suggests that people with mental disorders may not have capacity to request assisted suicide. This is imprecise and could be taken to exclude all people with a mental disorder from being able to make a request, because it is a blanket approach to capacity with regard to mental disorder (see comments below on capacity, section 12). We suggest that this may be discriminatory.

It is important to note that mental illness is extremely common, much more so than the type of chronic physical condition for which we suspect that this Bill has is intended to cover, and potentially there may be people with mental illness requesting assisted suicide.

We also note that section 8(5) simply refers to a illness which is terminal or life shortening but is silent on the life expectancy of the assisted person, therefore a person may fall under the provisions of the Bill even though he or she may have a life expectancy of a long (in the circumstances) period. Again, this can be contrasted with the Assisted Dying Bill [HL] which requires that the person, as a consequence of a progressive illness has a maximum life expectancy of six months.

We note that section 8 of the Bill, requires the assisted person to have only registered with a medical practice in Scotland at the time of the first request. We further note that it does not require any period of domicile in Scotland or any knowledge or relationship to have been formed with a medical practitioner. Is this sufficient for a medical practitioner to be able to make an assessment, particularly if the person may not have English as a first language? We would suggest that this would allow others from out-with Scotland to travel here for the purposes of ending his or her life under the provisions of the Bill.

This can be contrasted with the Assisted Dying Bill [HL] section 1(2) which requires a person seeking to end his or her own life to have been a resident in England and Wales for not less than 1 year.

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23 section 64(5)(b) of the 2003 Act and section 57A(3)(b) of the Criminal Procedure (Scotland) Act 1995
24 Mental Health (Care and Treatment) (Scotland) Act, section 328
25 Assisted Dying Bill[HL] SECTION (1)(b) ‘...a person is terminally ill if that person ...as a consequence of that illness is reasonably expected to die within six months...’
26 Assisted Dying Bill[HL] section 1(2) ‘...Subsection (1) only applies where the person—
Please also refer to our comments above, to section 4 and those relating to the proposed minimum age.

Section 12: ‘Capacity’
We have concerns relating to the definition of capacity as set out in section 12.
The Adults with Incapacity (Scotland) Act 2000 defines incapacity as being incapable of—

‘(a) acting; or
(b) making decisions; or
(c) communicating decisions; or
(d) understanding decisions; or
(e) retaining the memory of decisions,

by reason of mental disorder or of inability to communicate because of physical disability; but a person shall not fall within this definition by reason only of a lack or deficiency in a faculty of communication if that lack or deficiency can be made good by human or mechanical aid (whether of an interpretative nature or otherwise27)

The Mental Health (Care and Treatment) (Scotland) Act 2003, when deciding if a person has the ability to make decisions about medical treatment, uses28 the significant impairment of decision making ability ("SIDMA") test- ‘…that because of the mental disorder the patient’s ability to make decisions about the provision of such medical treatment is significantly impaired…’29

Section 12(1)(b) appears to use strands from the 2000 Act, in a converse fashion. Section 12(1)(a) makes no reference to the SIDMA test, although refers specifically to mental disorder. Any reference to capacity to make a request within the Bill must be consistent with both the Adults with Incapacity (Scotland) Act 2000 and the Mental Health (Care and Treatment) (Scotland) Act 2003.

Section 13: ‘Recording in medical records of making of requests and associated statements’
Section 13 addresses the facts to be recorded in a declaration. The provisions anticipate a single document which will contain all associated statements. We note that the Bill does not address storage of the documents.

The Bill does not fully address how multiple documents which might be signed at multiple locations by different practitioners will be collated and stored together. What happens if a medical practitioner fails to communicate to the

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27 Adults with Incapacity (Scotland) Act 2000 Section 1(6) http://www.legislation.gov.uk/asp/2000/4/section/1
28…except where this involves a compulsion order or a compulsion order and restriction order, for which there is no SIDMA test
29 Section 64(5)(d)
registered practitioner that a second declaration has been signed? How is the registered practitioner to be notified?

There should be a central registry which operates in a manner similar to the Office of Public Guardian that may provide a more secure and centralised location for such documents. This would provide formal registration of declarations and cancellations and reduce opportunities for documents to be misplaced or mis-filed.

Section 14: ‘Each request and associated statements to be in one conventional document; back up copy’
We note that section 14(3) prohibits electronic documents. Given developments in relation to electronic signatures and documents, we would suggest that further consideration be given to this. The basis and concern for prohibiting electronic documents has not been made out.

Section 16: ‘Signing by proxy of preliminary declarations, first and second requests and cancellations’
As referred to earlier in our response, section 16 is primarily a reiteration of section 9 of the Requirements of Writing (Scotland) Act 1995. However, a significant addition within section 16 of the Bill, and not a requirement under which section 9 of the Requirement of Writing (Scotland) Act operates, is the requirement at section 16(4) of the Bill that a ‘…proxy may not sign a document unless satisfied that the person understands its effect.’

A proxy is the authority to represent someone else. Of itself, this function does not give rise any particular additional duties upon the proxy. The requirements under section 9 of the 1995 Act do not require (nor did it intend) that a proxy undertakes this additional responsibility of ensuring that a person understand the effect of a document to which the proxy is subscribing.

Given the nature of the provision in section 16 of the Bill, it is suggested that it is not appropriate to use the model in section 9 of the 1995 Act. Section 16 of the Bill is of a different character to the intention of section 9 of the 1995 Act which seeks to facilitate execution but does not require a test of understanding.

The introduction of the obligation at section 16(4) of the Bill is an understandable safeguard; however, it introduces additional responsibility upon a proxy to make assessments in relation a person’s capacity and understanding. It is submitted that this changes what is primarily a ‘notarial’ function into something more. It also gives rise to a question as to whether a solicitor is an appropriate individual to perform this function in this context.

Section 17: ‘The act of suicide: time limit’
We note that section 2 (2) states that the suicide or attempted suicide must ‘…take place within the period of 14 days…’ following on from the second request. Following the assisted person’s second request it is, as we understand, the Bill's intention that a prescription for the drugs/products to facilitate the act of suicide be issued to the assisted person.
As we further understand, it is the intention that the time limit commences from the date of the signing of the second request and the issuing of the drug prescription by the GP, rather than when the assisted person subsequently gets the prescription dispensed. We suggest that there may be a delay between the issuing of the prescription to the assisted person and the point at which the assisted person takes the prescription to be dispensed. For the avoidance of doubt, we would suggest that clarification of the time limit be considered and clearly set out.

In addition, and further to the 14 day time limit, we would suggest and are concerned that this could place pressure on the assisted person and cause further anxiety beyond that which they may be already (and likely to be) experiencing.

Conversely it is not unreasonable to limit the time period for either dispensing of the prescription or for the time that the drug or other substance or means dispensed are stored in a domiciliary setting.

As section 2(2) sets out express time limits, we suggest that a number of further questions need to be considered. How, for example, is this 14 days to be monitored? Will the person be advised that their 14 days is about to expire? How will this information be given? Will this place a person under increased pressure to end their lives? What happens if the person asks for more time—perhaps a few more hours or a day? We also note that in direct contrast, the Assisted Dying Bill [HL] expressly states that a person to whom assistance is to be provided must wait for a period of at least 14 days since the final declaration (request) before self-administering the ‘medicine’ to take their own life. This, we suggest, provides the assisted person with time to reflect and consider fully the implications of their request.

Section 18: ‘Nature of assistance; no euthanasia etc’
Section 18 prevents euthanasia and section 19 sets out the general functions of licensed facilitators.

Section 18 provides that the death must have been as a result of the person’s own deliberate act. Section 19 (a) provides that licensed facilitators should provide such practical assistance as the person reasonably requests. That has to be read alongside section 18 (3) which provides that such assistance must be short of an act which causes the persons death. Reading section(s) 18 and 19 together, the Bill allows assistance to be given along with comfort and reassurance but prevents the taking of life and “encouragement”. We would question how reassurance is to be differentiated from encouragement in practice, this is likely to be a fine line and without clear definitions licensed facilitators may be uncertain as to the extent of their involvement and will need to be very careful that their actions and verbal comfort and reassurance cannot be interpreted adversely. A clear definition of ‘Facilitator’ is required. What is ‘assistance’ and how much assistance could a facilitator provide

30 Assisted Dying Bill [HL] section 2 (2)(d) ‘...after a period of not less than 14 days has elapsed since the day on which the persons declaration took effect...’
before their actions go beyond what is permitted under the provisions of the Bill? The Bill fails to clearly define what assistance is. We do recognise that it may be difficult to define ‘assistance’ with any certainty as this may always be subjective, depending on the abilities of the assisted person, but never the less, this should be clearly set out to avoid any doubt and uncertainty with interpretation.

We note that the policy memorandum states\(^3\) that section 18 makes explicit that it ‘must be the person’s own deliberate act that is the cause of death (or would have been, in the case of an attempt).’ We assume that this is to provide a distinction between the act of assistance and that of euthanasia. There are variations inherent in each of these definitions, but it is suggested that the fundamental distinction between the two concerns roles and responsibilities.

Voluntary euthanasia, in all its forms, places the responsibility for overseeing and bringing about the death upon a person other than the one wishing to end their life. In assisted suicide, the assistance is provided by another but it is the person themselves, who wishes to end their life, who has the responsibility to bring about their own death.

Such distinctions are not always clear and it is worth noting that when legislation was passed in Oregon\(^2\), some of the first challenges came from those who argued that if they wished to end their lives they were precluded from doing so because, due the nature of their disease, they lacked the ability to hold the medication in their hands, or put it in their mouths and ingest it. This was particularly resonant with those with a progressive neurological disease. If assistance is provided, at what point does it cease to be assistance and instead, become euthanasia- the primary responsibility having passed to another to bring about death? There is whole spectrum of what may be construed as assistance- helping someone travel to another country to die (to date the law has not recognised this as assistance) but is holding a person’s head up, or putting pills into their hands or mouths or giving them a glass of water, euthanasia or assisted suicide?

Section 19: ‘General functions of licensed facilitators’
We note that this section describes the general role of the licensed facilitator which includes amongst other matters ‘... to remove from the person any such drug or other substance or means still in the persons possession’\(^3\) at the end of the 14 day period or (presumably) after the act of suicide.

Section 19 does not address either the safe keeping aspects of the drug or other substance or means dispensed (to be) used or require any record keeping of when and what was consumed by the assisted person and what remains, if anything, of those drugs/substances which requires removal and return to a pharmacist for destruction purposes. To address these omissions, we would suggest that a duty is placed on the facilitator to record when and

\(^3\) SP Bill Policy Memorandum paragraph 42
\(^2\) Death With Dignity Act 1995
\(^3\) Assisted Suicide (Scotland) Bill Section 19 (d)
what was administered by the assisted person and this record should subsequently go for storage with the requests and associated statements of the assisted person.

If the drug or other substance or means dispensed are not used, we note that there appears to be an omission in the Bill of a requirement or obligation on the assisted person to return the drug/substance to the dispensing pharmacist at the close of the 14 day period. If this requirement is to be on the facilitator, how will they ensure access to the assisted person’s property to recover the drug/substance if the assisted person denies them access? If there is such a requirement on the facilitator, how will this be enforced? Please refer to our earlier comments, regarding safekeeping and the provisions of the Assisted Dying Bill [HL].

Section 20: ‘Reporting to the police’
Section 20 requires that where a person who the facilitator has assisted to commit suicide has died, or has attempted to commit suicide, or that the facilitator has a belief that the foregoing has taken place ‘…the facilitator must report that fact or belief to a constable as soon as practicable…’

Whilst concepts of dignified death have been taken out of the Bill, we believe that it is worthy of note that depending upon the record keeping of the licensed facilitator there may require to be a police investigation which will be, by its nature, intrusive whilst the police clarify that the suicide has taken place in accordance with the principles set out in the Bill.

It is further worthy of note that the requirement in other pieces of legislation which might broadly be called medical deaths there is a requirement to report to the PF rather than the police. Whilst practical import of reporting to a constable may be the same as the constable is subject to the instruction of the PF the Bill is notable in involving the police rather that PF at this stage.

Section 21: ‘Licensed facilitators: disqualifying relationships and minimum age’
We note that schedule 4 section 2 (g) states a disqualifying relationship for a facilitator to be ‘…anyone who will gain financially in the event of the person’s death whether directly or indirectly and whether in money or money’s worth…’
As referred to above, we would suggest that this could be become a live issue post assisted suicide as the person who did act as a facilitator may not have been aware at the time of providing assistance that he or she was named in the assisted suicide person’s will or stood to benefit financially in some other way from the death of the assisted person. The Bill is silent on how such circumstances would be addressed.

We note that the Bill provides for any person 16 years and over to be a licensed facilitator (section 21(2) ). We believe that the age limit is too low taking into account the high degree of responsibility which the role of the licensed facilitator involves. This, we suggest, should be a minimum of 18 years of age.
Section 22: ‘Licensing of facilitators’
Section 22 is inadequate in that it fails to take into account a number of things that any regulations should also cover, such as complaints process, insurance and liability.

Also no indication is given as to what body or association may be appointed as a ‘licensing authority’. For example, will this be a newly formed (for the purposes of being a licensing authority) body or association or perhaps a medical association or body currently in existence? Section 22(1)(a) is vague as it provides a number of options ‘…a person or a body, association or group of persons…’ This gives a very wide discretion.

Section 22(4) provides that any regulations shall be subject to the negative procedure. We suggest that given the nature of the subject matter, the affirmative procedure would be more appropriate.

Section 24: ‘Savings for certain mistakes and things done in good faith’
We note that whilst the Bill puts in place a legislative framework of intended safeguards for assisted suicide, section 24 makes what are described as savings.

We believe and suggest that the provisions of section 24, in practice has the effect of diluting a number of the safeguards in that if a person is acting ‘…in good faith, and intended pursuance…’ of the Bill, makes an incorrect statement or otherwise does anything inconsistent with the Bill then, we suggest, they do not commit a crime and are not liable in civil law. We further suggest that this leaves a wide discretion to a court to interpret what intended pursuance of the Act actually means, is it any act or omission in pursuance of suicide or attempted suicide decriminalised if done in good faith? If so then, it is suggested, it may well be that ignorance of the law is a defence in relation to this Bill. Section 24 is so widely worded as to make practical enforceability very difficult.

Whilst it appears that the policy intention is to ensure that those involved in assisted suicide are not to be criminalised by the law of homicide by virtue of technical or administrative failures, its effect potentially goes far beyond that.

Schedule 1
We note that in schedule 1 the person must declare that ‘…I am willing to consider whether to request [assistance to commit suicide]…’. It is suggested that this is an unusual turn of phrase and is distinct from the terms in the subsequent Schedule where the person directly “asks” for assistance. It is suggested that the word “willing” infers an element of suggestion to the person and perhaps presupposes a question as to whether or not a person would or would not be willing to consider assisted suicide. We would suggest that the initial request in the preliminary declaration reflect the same position as subsequent declarations and reflect a clear request from a person rather than “willingness” which might infer a less clear and independent request.

The Law Society of Scotland