The Committee will meet at 9.30 am in the David Livingstone Room (CR6).

1. **Decision on taking business in private:** The Committee will decide whether to take item 4 in private.

2. **Assisted Suicide (Scotland) Bill:** The Committee will take evidence on the Bill at Stage 1 from—

   Professor Alison Britton, Convenor, Health and Medical Law Committee, and Coral Riddell, Head of Professional Practice, Law Society of Scotland;

   David Stephenson QC, Faculty of Advocates;

   Professor Alan Miller, Chair, Scottish Human Rights Commission;

   and then from—

   Chief Superintendent Gary Flannigan, Head of Major Crime, Specialist Crime Division, Police Scotland;


3. **Drink driving limit:** The Committee will take evidence on the Road Traffic Act 1988 (Prescribed Limit) (Scotland) Regulations 2014 [draft] from—

   Chief Superintendent Iain Murray, Police Scotland;

   Dr Peter Rice, Chair, Scottish Health Action on Alcohol Problems;

   Margaret Dekker, Researcher/secretary, Scotland's Campaign against Irresponsible Drivers.

4. **Work programme:** The Committee will consider its work programme.
The papers for this meeting are as follows—

**Agenda item 2**

Paper by the clerk

J/S4/14/26/1

Private paper

J/S4/14/26/2 (P)

*Assisted Suicide (Scotland) Bill and accompanying documents*

*Analysis of submissions of evidence on the Assisted Suicide (Scotland) Bill*

**Agenda item 3**

Paper by the clerk

J/S4/14/26/3

Private paper

J/S4/14/26/4 (P)

*Road Traffic Act 1988 (Prescribed Limit) (Scotland) Regulations 2014*

**Agenda item 4**

Private paper

J/S4/14/26/5 (P)
Justice Committee

26th Meeting, 2014 (Session 4), Tuesday, 28 October 2014

Stage 1 - Assisted Suicide (Scotland) Bill

Note by the clerk

Purpose

1. This paper provides background to the Committee’s Stage 1 consideration of the Assisted Suicide (Scotland) Bill.

Background

2. The Assisted Suicide (Scotland) Bill\(^1\) was introduced in the Parliament on 13 November 2013 by Margo MacDonald MSP. Patrick Harvie MSP has been designated as member in charge of the Bill and so will take the Bill through its various legislative stages in the Parliament.

3. The Parliament has designated the Health and Sport Committee as lead committee in consideration of the Bill, with the Justice Committee designated as secondary committee.

4. The Health and Sport Committee issued a call for evidence on 13 March which closed on 6 June. The Committee has received 886 written submissions\(^2\). An analysis of these submissions was published on 25 September\(^3\).

Timetable

5. As secondary committee, the Justice Committee is required to report to the Health and Sport Committee which is due to consider the Bill at Stage 1 in January and February. The Justice Committee is required to report to the Health and Sport Committee to inform its evidence session with the Member in Charge of the Bill. This session is currently scheduled to take place on 3 February.

Justice Committee scrutiny

6. The Bill sets out a process that a person seeking an assisted suicide is to follow. The Bill also provides legal protection to those involved in providing assistance to the person who commits suicide. That protection is against both criminal and civil liability and is subject to essential safeguards in the Bill being complied with.

7. The Justice Committee has agreed to focus its scrutiny on the criminal and civil liability aspects of the Bill and their relation to the process set out in the Bill. In addition,

\(^1\) Assisted Suicide (Scotland) Bill. Available at: http://www.scottish.parliament.uk/parliamentarybusiness/Bills/69604.aspx

\(^2\) Assisted Suicide (Scotland) Bill. Written submissions. Available at: http://www.scottish.parliament.uk/parliamentarybusiness/CurrentCommittees/79119.aspx

\(^3\) Assisted Suicide (Scotland) Bill. Analysis of written submissions. Available at: http://www.scottish.parliament.uk/S4_HealthandSportCommittee/Reports/HS_Assisted_Suicide_Report.pdf
its scrutiny of the Bill will include consideration of human rights, in particular, compliance of the provisions with convention rights.

8. The Committee has agreed to take evidence at this meeting from representatives of the Law Society of Scotland, the Faculty of Advocates and the Scottish Human Rights Commission in its first panel of witnesses. This will be followed by a panel comprising of representatives from Police Scotland and the Crown Office and Procurator Fiscal Service.

9. The written submissions provided by these witnesses are attached in the annexe to this paper.
Submission from 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 2013⁴, 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 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

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Scottish Executive from making any legislation which is incompatible with Convention rights\(^5\). 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 …’\(^6\)

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\(^7\).

**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\(^8\) (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 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.

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\(^5\) 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’

\(^6\) Ibid Section 29(2)(d)

\(^7\) 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’

\(^8\) 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.
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 legislation\(^9\) 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’ legislation\(^10\) 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 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)\(^11\). 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.

\(^9\) Belgian Act of Euthanasia 2002, Chapter III, section 4 (1)
\(^10\) Termination of Life and Assisted Suicide Act 2002
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…”’ (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

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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…”

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13 The Scotland Act 1998 Section 29(2) (a)
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?

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) Bill\(^1\) 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’\(^2\). 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

\(^1\) http://www.scottish.parliament.uk/S3_Bills/End%20of%20Life%20Assistance%20(Scotland)%20Bill/b38s3-introd.pdf
\(^2\) http://archive.scottish.parliament.uk/s3/committees/endLifeAsstBill/reports-10/ela10-01-vol1.htm
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 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\(^{16}\), 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.

\(^{16}\) Death With Dignity Act 1995
6. Are you satisfied with the eligibility requirements as regards age, capacity, and connection with Scotland as set out in the Bill?

**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 2\textsuperscript{17} 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\textsuperscript{18}. 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…’\textsuperscript{19}

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.

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…’\textsuperscript{20}, we would

\textsuperscript{17} 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.’

\textsuperscript{18} Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide


\textsuperscript{19} Director of Public Prosecutions, Keir Starmer QC


\textsuperscript{20} Assisted Suicide (Scotland) Bill Section 19 (c).
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 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\textsuperscript{21}. 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

\textsuperscript{21} Assisted Dying Bill [HL] section 2(4)(5) and (6)
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 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 state 22 ‘...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 proposed 23. It is up to the doctor to decide

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22 Assisted Suicide (Scotland) Bill Explanatory Notes: Paragraph 13
23 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
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 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...’24 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 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 potentially 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

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24 Assisted Dying Bill [HL] section 1(c) (i)
assistance. This includes a provision that the person has, after reflecting on the consequences for that person of the considerations set out in section 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 (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.

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25 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
26 section 64(5)(b) of the 2003 Act and section 57A(3)(b) of the Criminal Procedure (Scotland) Act 1995
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\(^{27}\) 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\(^{28}\).

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\(^{29}\).

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—

\[\text{(a) acting; or} \]
\[\text{(b) making decisions; or} \]
\[\text{(c) communicating decisions; or} \]
\[\text{(d) understanding decisions; or} \]

\(^{27}\) Mental Health (Care and Treatment) (Scotland) Act, section 328

\(^{28}\) 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...’

\(^{29}\) Assisted Dying Bill[HL] section 1(2) ‘...Subsection (1) only applies where the person—(ii) has been ordinarily resident in England and Wales for not less than one year...’
(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 otherwise\textsuperscript{30})

The Mental Health (Care and Treatment) (Scotland) Act 2003, when deciding if a person
has the ability to make decisions about medical treatment, uses\textsuperscript{31} 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…’\textsuperscript{32}

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 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

\textsuperscript{30} Adults with Incapacity (Scotland) Act 2000 Section 1(6)
\textsuperscript{31}…except where this involves a compulsion order or a compulsion order and restriction order, for which
there is no SIDMA test
\textsuperscript{32} Section 64(5)(d)
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 \(^3^3\). 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 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\(^3^4\) 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\(^3^5\), 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

\(^3^3\) 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…’

\(^3^4\) SP Bill Policy Memorandum paragraph 42

\(^3^5\) Death With Dignity Act 1995
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’ 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 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 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

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36 Assisted Suicide (Scotland) Bill Section 19 (d)
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
Submission from the Faculty of Advocates

Introduction
The Faculty of Advocates is the independent bar in Scotland. It is committed to human rights and to equal opportunities for all. Its members include advocates with expertise in all fields of law. The Faculty welcomes the opportunity to offer evidence in relation to the Assisted Suicide (Scotland) Bill. The Faculty does not express views on matters of social policy and neither supports nor opposes the policy which this Bill pursues. The comments which the Faculty makes are on technical and legal features of the Bill.

Response to Questions in the Call for Written Evidence
In relation to the specific questions to be addressed the Faculty has the following comments.

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?
The Faculty considers that it would not be appropriate for it to comment on this question.

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?
No. The Faculty considers that the Bill currently under consideration should be the focus of attention.

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?
Yes, please see the Appendix to this response

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?
Yes, please see the Appendix to this response.

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?
In general terms, yes. Many conditions are life-shortening, including common conditions such as type II diabetes and hepatitis. The Faculty questions whether it is the intention of the proponents of the Bill that such common conditions should justify assisted suicide. The Faculty considers that, if assisted suicide is to be legalised, the circumstances in which assisted suicide attracts the protection of the Bill should be clearly and precisely defined in order to assist persons who wish to rely on the protection such legislation would provide, as well as those persons performing functions in terms of the legislation. All such persons need to understand clearly what they can do to assist a suicide, and when and how that can be done. Clarity is imperative. Otherwise such persons may find their actions subject to review in the courts by way of a criminal prosecution or otherwise.

6. Are you satisfied with the eligibility requirements as regards age, capacity, and connection with Scotland as set out in the Bill?
Please see the Appendix to this response.
7. Do you have any comment on the roles of medical practitioners and pharmacists as provided for in the Bill?
The Faculty understands that the General Medical Council and the General Pharmaceutical Council would require to amend their regulations before their members could participate in the activities outlined in the Bill. Whether they are willing to do so is a matter for these professional bodies.

8. Do you have any comment on the means by which a person would be permitted to end his/her life under the Bill?
The Bill does not address this issue save by implication at section 19(c) (cf. the Explanatory Notes). Please see further below in the Appendix to this response.

9. Do you have any comment on the role of licensed facilitators as provided for in the Bill?
The Faculty is concerned that the role of licensed facilitators is insufficiently specified. The Faculty wonders whether such a difficult and sensitive role should be be carried out only by persons with certain recognised qualifications. What these qualifications might be is a matter which the Faculty considers the health and caring professions are better qualified to address. The Faculty questions whether it is appropriate that such a role should be performed by a person as young as 16 years of age, and particularly so if they have no relevant qualifications to allow them to perform that role.

10. Do you have any comment on the role of the police as provided for in the Bill?
Yes. Please see the Appendix to this response.

11. Do you have any comment to make about the Bill not already covered in your answers to the questions above?
Yes. Please see the Appendix to this response.

Appendix

General observations:
If Parliament is to pass legislation to protect persons from what would otherwise be the legal consequences of assisting another person to commit suicide, the Faculty considers it is important that such legislation is clear, readily understood (and not just by lawyers), that key terms are well-defined and not open to a variety of interpretations, and that the penalties for breach of the requirements of the legislation are spelled out. Otherwise persons wishing the protection of the legislation will be unclear as to whether their acts are protected and may render themselves liable to prosecution for serious crimes or subsequent review of their conduct in a civil court. The Faculty considers that the Bill as currently drafted may not achieve these essential goals.

The complexity of the Bill is well-illustrated by the essential safeguards in section 3 of the Bill. To understand these requires reference to sections 4, 5, 8, 10, 17 and 18.

The Faculty considers that the requirements in sections 4, 8 and 10 of the Bill that the person making the preliminary declaration, and first and second requests for assistance be a patient registered with a medical practice in Scotland are practicable ways of limiting those to whom the protection of the Bill extends. However, the Faculty also wonders if this should be supported by a requirement that the registration should be for a minimum period before the preliminary declaration and first and second request may be made.
Capacity:
Section 12 of the Bill makes provision for the capacity of the person making the first or second requests for assistance. Capacity is central to the statement to be made by the medical practitioner in terms of sections 9 and 11. The Faculty considers it undesirable to define capacity, first by reference to section 328 of the Mental Health (Care and Treatment) (Scotland) Act 2003 (asp 13) - which would e.g., exclude anyone with a mental disorder - and also by reference to what is effectively the converse of an edited version of the definition of “incapable” contained in section 1(6) of the Adults with Incapacity Act 2000. The Faculty considers that it is important that the definition of “capacity” in the Bill is consistent with both the Adults with Incapacity Act 2000 and the Mental Health (Care and Treatment) (Scotland) Act 2003 (asp 13) 1(6) (asp 4), and that conflict between statutory regimes is avoided. There may be good policy reasons for seeking to exclude from the ambit of the Bill those suffering from a mental disorder, but Faculty would be concerned such a general exclusion might be seen as discriminatory. Faculty are not clear whether the policy intention is in fact to exclude everyone with a mental disorder from the scope of the Bill, or why that should necessarily be the case if that person meets the requirements of Section 12(1)(b)(i): "is capable of - (i) making a decision to make the request“. Faculty is also concerned as to what would therefore qualify “a medical practitioner” to make a decision as to capacity for the purposes of Sections 9(2)(a) and 11(2)(a), and whether the practical consequences might be that only a psychiatrist would have the necessary skills.

Savings:
Section 24 provides for “Savings for certain mistakes and things done in good faith”. The Faculty notes that the terms “careless” and “in good faith” are not (defined in the Bill. The Faculty considers they ought to be defined. These terms are the dividing line between conduct that is lawful and protected by the Bill and conduct that exposes a person to the risk of prosecution. As currently drafted it is not clear by what standard carelessness is to be judged. Is it to be tested objectively or subjectively, or by a combination of both? Is the same standard to be applied to medical practitioners as to licensed facilitators and lay persons?

The width of the protection extended by section 24 may blunt the essential safeguards elsewhere in the Bill.

Section 24 (3) is confusing. From paragraph 44 of the Explanatory Notes it appears that the intention is to preserve “the validity” of the acts of a person acting in good faith and in intended furtherance of the Act where someone else has breached the Act in bad faith or carelessly. If this is the intention the words “by another person” should be inserted in section 23 (3) (a) after the word “made”, and in section 23 (3) (b) after the word “done”.

Proxies:
The Faculty has concerns as to the identification of its members as potential proxy signatories for the purposes of Section 16 of the Bill. Section 16(6) defines “proxy” to mean “a member of the Faculty of Advocates”. The Faculty is unclear whether involvement of its members as proxies is seen as being in the performance of a professional function or not, and would have to consider carefully with professional indemnity insurers who provide cover for advocates whether members could, or should, be permitted to perform the function envisaged. The Faculty’s concerns are compounded by the uncertainties in the present Bill as to how the statutory indemnity against criminal sanction and civil liability would apply in practice.
Conscience:
The Faculty notes that the Bill does not contain a “conscience” provision for those who feel that they cannot participate in assisting a suicide. This may be contrasted with the Abortion Act 1967. The Faculty considers such a provision may be desirable.

If there is to be a “conscience” clause the Faculty suggests that it should impose an obligation on the person declining to assist to inform the person making a preliminary declaration or first or second request that their reason for declining to assist is based upon conscience rather than upon a failure by the person to meet the statutory qualifying criteria. The person can then decide, if they wish, to seek assistance from somebody else.

Facilitators:
The role of a licensed facilitator is unclear. The Faculty considers it desirable that this potentially crucial role should be clearly defined in the legislation and not left to directions or guidance that may be issued by the Scottish Ministers. The Faculty notes that there is no express requirement that a facilitator be engaged, or if engaged that his/her services be used as one of the safeguards – cf. paragraph 7 of the form of second request in Schedule 3 to the Bill. Is the facilitator the only person who can assist a person to commit suicide? Such protections as the Bill provides in relation to the role of a facilitator could readily be elided if persons other than licensed facilitators were able to assist a person to commit suicide. For example, a spouse (who would be disqualified from acting as a facilitator under Schedule 4) could assist her husband or wife to commit suicide. (A spouse might be thought to be equally able to provide “such practical assistance as the person reasonably requests” and better equipped than a facilitator to provide “comfort and reassurance” to the person committing suicide.)

Section 19 provides that the facilitator is to use best endeavours to be present when the person committing suicide takes the drugs or uses other means to commit suicide. Best endeavours sets a high standard of compliance, particularly for someone who has no powers of enforcement. The phrase “reasonable endeavours” or “all reasonably practicable endeavours” might be more appropriate. It is not clear whether the facilitator requires to remain with the person until he dies. The facilitator is also to provide such practical assistance as the person wishing to commit suicide reasonably requests. The Faculty notes the tension between this provision and the requirement that the person’s death be his own deliberate act. The Faculty questions whether an unqualified 16 year old unrelated to the person who wishes to commit suicide is in practice likely to be able to provide that person with adequate “comfort and reassurance”.

The Faculty notes that the Bill does not specify the means by which a person might commit suicide. Section 19 seems to envisage that a person would commit suicide by ingesting drugs. It is not clear from the Bill who is to prescribe these drugs and whether there is to be any control over what drugs may be prescribed and dispensed for the purpose of assisting a person to commit suicide (although we note that paragraph 39 of the Policy Memorandum envisages that it will be the role of a medical practitioner and that guidelines and codes of practice will require amendment). The Faculty is unclear from the wording of the Bill whether or not it is intended to extend protection to the use of other methods by which a person might commit suicide. The Policy Memorandum seems to envisage that this is so (cf. Paragraph 40). If that is not the intention it is suggested that the present provisions should be looked at again to ensure that the legislative intention is clearly expressed.

It is not clear why deaths or attempts to commit suicide should be reportable to the
police and not, as is generally the case in Scotland, to the Procurator Fiscal. The Committee might consider amending the terms of the Fatal Accident and Sudden Deaths Inquiries (Scotland) Act 1976 to make deaths covered by the Bill reportable.

**Other drafting points:**
The Faculty considers that what constitutes “assisting a person to commit suicide” should be clearly defined in the Bill. Other than the fact that the cause of the person’s death must be his own deliberate act (sections 3 (d) and 18 (3)) the Bill offers no guidance as to what assistance comprises. Does it include prescribing or dispensing drugs to the person who wishes to commit suicide? Does it include preparing the means whereby the person can ingest such drugs? Does it cover the actions of the licensed facilitator?

The Faculty considers section 18 to be poorly drafted. From paragraph 34 of the Explanatory Notes it appears that the purpose of the provision is to ensure that the protection of the Bill does not extend to euthanasia and that the cause of death must be the person’s own deliberate act. What is meant by the “cause” of a person’s death? There may be multiple causes. The Faculty considers that this could be more clearly expressed, and suggests that the phrase “final act” is to be preferred to “cause” – cf. clause 4 (4) of Lord Falconer’s Assisted Dying Bill for England and Wales where the procedure requires the assistance of a health professional.

The Faculty also considers that the wording of sections 8 (3) (d) and 8 (4)(b) might be better phrased. The same changes could be made mutatis mutandis to section 10 (3) and (4).

The wording of paragraph 8 of the preliminary declaration in schedule 1 to the Bill might be better phrased.

**Penalties and regulation:**
The Faculty notes that the Bill contains no sanctions or penalties for contravention of its provisions. A person assisting another to commit suicide is likely to want to be clear as to the potential consequences of a failure to comply with the requirements of the Bill.

The Faculty considers it desirable that breaches of the terms of the Bill attract specific penalties rather than being subject only to the common law.

In particular, there is no penalty in the event that a medical practitioner wrongly endorses a request for assistance in terms of sections 9 or 11, or for a failure to comply with procedural matters such as the form of a preliminary declaration or request, the form of endorsement of these by a medical practitioner, the recording of the making of a preliminary declaration or request (or the cancellation of any of these).

The Faculty considers that the consequence of a person’s failure to ensure that an attempted suicide takes place within 14 days of the recording of the second request should be expressly stated. As presently drafted, it appears to be implied that the second request will fall after 14 days have expired and that a further second request would be required to give the protection of the Bill to a person assisting in a subsequent attempt to commit suicide.

The Bill lacks detail about the requirements of record keeping by the various parties involved, and the inspection of those records (which would ordinarily be confidential to the patient) to prevent abuse. Is there to be a system of regulation? The Faculty
wonders whether a centralised system of reporting and collation of information in relation to assisted suicides might be desirable, in order to monitor the system and compliance with its requirements, coupled with publication of statistical information and an annual report on the operation of the scheme.

Faculty of Advocates
Submission from the Scottish Human Rights Commission

1. Introduction

The Scottish Human Rights Commission (the Commission) welcomes the opportunity to submit the following comments and recommendations on the Assisted Suicide (Scotland) Bill.37

The central purpose of this response is to ensure an informed and balanced parliamentary and public debate on the subject. Accordingly, the Commission focuses on three key issues:

- the relevant human rights legal framework,
- the principles of dignity and autonomy, and
- the need for clarity both in the current criminal legal system and in procedures where States do permit assisted suicide.

The issue of assisted dying has long been a topic of moral, ethical and jurisprudential discussion. In human rights law it is related to the right to life, the right to freedom from degrading treatment, the right to respect for private38 and family life, and the right to freedom from discrimination. Each of these is considered in section a). There is also a broader legal framework that includes various human rights instruments, some of them are cited below.

2. General Legal Framework

- Scotland Act 1998
- Human Rights Act 1998 (HRA)
- European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR)
- European Social Charter
- Adults With Incapacity (Scotland) Act 2000 and the Code of Practice relating to Part 5 (Medical Treatment)
- UN Convention on the Rights of Persons with Disabilities
- Council of Europe's Recommendation 1418 (1999) on the protection of the human rights and dignity of the terminally ill and the dying

As a matter of domestic law, the HRA 1998 and the Scotland Act 1998 incorporate the Articles of the ECHR into our domestic law. According to the HRA a court or tribunal must take into account the jurisprudence of the European Court of Human Rights (ECtHR) when determining a question which arises in relation to a Convention right (section 2 of the HRA). The HRA also provides that it is unlawful for public authorities to act in a way which is incompatible with a Convention right (section 6 of the HRA). Furthermore legislation must be read and given effect in a way which is compatible with the Convention rights (section 3 of the HRA).

37 The Commission acknowledges the contributions from Dr. Mary Ford and Professor Sheila McLean, which have helped to inform this submission. Both produced background papers which are available from the Commission on request.
38 See X and Y v. the Netherlands, judgment of 26 March 1985
a) Human rights law framework

The Commission must emphasise the fact that there is no consensus on the subject of assisted dying at European level. State parties to the ECHR take different positions. There are some countries that have legalised assisted suicide. Some countries expressly forbid it. Others countries do not specifically proscribe assisted suicide in law. Furthermore, the European Court of Human Rights (ECtHR) has not taken the view that the Convention requires either the prohibition or the permission of assisted suicide. The approach of the ECtHR is to recognise that domestic authorities are better placed than the Court to decide on nationally sensitive issues (allowing a ‘margin of appreciation’). However, that should be accompanied by the obligation of the State to ensure that offences are clearly defined in law. In other words, a clear policy as to when it would, and would not, be appropriate to prosecute individuals who help others to die is indispensable.

The subject of assisted dying has been discussed extensively in Pretty v. UK. Any discussion on this subject should, at least, consider the following Articles of the Convention:

- Article 2 – “Everyone’s right to life shall be protected by law. No one shall be deprived of his life intentionally…”
- Article 3 – “No-one shall be subjected to torture or to inhuman or degrading treatment or punishment”;
- Article 8 – “the right to respect for his private and family life, his home and his correspondence”;
- Article 14 – the enjoyment of Convention rights “without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.”

Article 2- “Everyone’s right to life shall be protected by law. No one shall be deprived of his life intentionally…”

This Article proscribes the intentional taking of life except in strictly limited circumstances. Article 2 of the Convention also requires the State Party to take preventative operational measures to protect an individual whose life is at risk from the criminal acts of another individual. States thus are required to regulate, through the operation of general criminal laws those activities that are detrimental to the life and safety of other individuals. “The consistent emphasis in all the cases before the Court has been the obligation of the State to protect life”, Article 2 is “unconcerned with issues

39 Pretty v. United Kingdom [2002] 35 EHRR 1
40 ARTICLE 2 of the ECHR
1. 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.
2. Deprivation of life shall not be regarded as inflicted in contravention of this article when it results from the use of force which is no more than absolutely necessary:
   (a) in defence of any person from unlawful violence;
   (b) in order to effect a lawful arrest or to prevent escape of a person lawfully detained;
   (c) in action lawfully taken for the purpose of quelling a riot or insurrection.

41 See Art. 2 (2) of the ECHR
42 Osman v. United Kingdom [1998] EHRR 101
to do with the quality of living". As a matter of UK policy, the prohibition on assisted suicide has been designed to protect some of the most vulnerable members of society.

Article 2 of the ECHR is concerned with the obligation to protect life, not with quality of life and therefore in Pretty v UK the Court concluded that a right to die could not be derived from Art 2. While this is the approach taken by the European Court of Human Rights, other bodies, including the Indian Supreme Court and the Inter-American Court of Human Rights have interpreted the right to life in a broader sense to include the requirements to live with dignity, such as access to clean water, sanitation and education.

Article 3- “no one shall be subjected to torture or to inhuman or degrading treatment or punishment”

This Article provides for the right not to be subject to inhuman or degrading treatment or punishment. This also requires appropriate positive action by the State to prevent the subjection of individuals to such treatment. In the Pretty case, the ECtHR considered that her “suffering was not flowing from conditions of detention, expulsion or other measures, for which the authorities can be held responsible”. The Court concluded in Pretty v UK that Article 3 has to be construed in harmony with Article 2. Therefore, Article 3 does not give rise to a positive obligation to prevent or ameliorate suffering attributable to the progression of a disease by authorising killing.

Article 8- “the right to respect for his private and family life, his home and his correspondence.”

The scope of this Article is very broad. The ECtHR has stated that the element of “private life” alone encompasses, among other things, “aspects of an individual’s physical and social identity including the right to personal autonomy, personal development and to establish and develop relationships with other human beings and the outside world”. Or even more broadly “to conduct one’s life in the manner of one’s choosing”. The extent of this right to autonomy and self-determination in relation to end of life decisions has been interpreted differently by the House of Lords and the ECtHR. After concluding that Article 8 was engaged in Pretty v UK, the ECtHR went
on to consider whether the interference with the rights under Article 8(1) was in accordance with the law, legitimate and necessary in a democratic society for the protection of the rights of others.\textsuperscript{53} In other words, whether the blanket nature of the ban on assisted suicide was justified under Article 8(2). The Court concluded that it was not disproportionate.\textsuperscript{54} The UK Supreme Court has, however, raised queries regarding the justification for a blanket ban on assisted suicide and invited Parliament to consider making amendments. Their concerns, articulated in the case of \textit{Nicklinson v Ministry of Justice}\textsuperscript{55}, were that

“The interference with Applicants’ article 8 rights is grave, the arguments in favour of the current law are by no means overwhelming, the present official attitude to assisted suicide seems in practice to come close to tolerating it in certain situations [and] the rational connection between the aim and effect of [the legislation banning assisted suicide] is fairly weak.”

The ECtHR has, in recent years, considered a number of further cases regarding the impact of assisted suicide provisions on Article 8 and has consistently found that it encompasses the right to decide how and when to die, and in particular the right to avoid a distressing and undignified end to life (provided that the decision is made freely)\textsuperscript{56}. They have, however, also consistently emphasised the wide margin of appreciation allowed to states to determine whether they will permit assisted suicide. \textit{These cases also highlight a need for clarity in procedures where states do permit assisted suicide}. Thus, they must take appropriate measures to protect abuse and to ensure that procedures are put in place which are capable of ensuring that a person’s decision to end his/her life does in fact reflect his/her free will\textsuperscript{57}. They must also ensure clarity as to the extent of the right to assisted suicide, to prevent anguish caused by uncertainty\textsuperscript{58}.

\textbf{Article 14- Prohibition of discrimination in the enjoyment of Convention rights. “without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.”\textsuperscript{59}}

The ECtHR has repeatedly held that this Article is not autonomous, but has effect only in relation to Convention rights. However, there is no need to identify an actual breach of a right to claim discrimination with respect to the enjoyment of it.\textsuperscript{60} For the purposes of Article 14 a difference in treatment between persons in analogous or relevantly similar positions was discriminatory if it had no objective and reasonable justification, or there was no reasonable relationship of proportionality between the means employed

\begin{itemize}
\item \textsuperscript{52} The Court concluded that Article 8 protects the physical and moral integrity of the individual, “including rights over the individual’s own body, but there is nothing to suggest that it confers a right to decide when or how to die.” \textit{Pretty v UK} 66 BLMR 147 (2002) at p163
\item \textsuperscript{53} Ibid, para. 68.
\item \textsuperscript{54} Ibid
\item \textsuperscript{55} \textit{R (on the application of Nicklinson) v Ministry of Justice} [2014] UKSC 38
\item \textsuperscript{56} \textit{Haas v Switzerland} (2011) 53 EHRR 33, para 51, \textit{Koch v Germany} (2013) 56 EHRR 6, paras 46 and 51, and \textit{Gross v Switzerland} (2014) 58 EHRR 7, para 60
\item \textsuperscript{57} \textit{Haas v Switzerland} (2011) 53 EHRR 33
\item \textsuperscript{58} \textit{Gross v Switzerland} (2014) 58 EHRR 7. This case was, however, subsequently declared inadmissible and is not therefore legally binding.
\item \textsuperscript{59} ARTICLE 14 of the ECHR. The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.
\item \textsuperscript{60} \textit{Van Raalte v. Netherlands} (1997) 24 EHRR 503 at p. 516, para. 33
\end{itemize}
and the aim sought to be realised. Discrimination could also arise where States, without an objective and reasonable justification, failed to treat differently persons whose situations were significantly different.\textsuperscript{61}

The Court concluded in \textit{Pretty v UK} that there was objective and reasonable justification for not distinguishing in law between those who were and those who were not physically capable of committing suicide.\textsuperscript{62}

\textbf{b) The principles of dignity and autonomy}

There are a number of general principles at play under the subject of assisted suicide such as autonomy, justice, solidarity and especially dignity. Any interpretation of the rights under the ECHR/HRA have also to accord with their fundamental objectives and their coherence as a system of human rights protection for all people.

Autonomy and dignity are predominantly used in contemporary discussions of medicine, health care and bioethics. The concepts of autonomy (self governance of individuals) and dignity (inner worth of human beings) have played an important role in human rights.

**Assisted suicide and human dignity**

Human dignity is the foundation and very essence of human rights. Human dignity is central to the work of the Commission.\textsuperscript{63} The concept of human dignity arises in both legal and ethical contexts. It is both a fundamental legal consideration and a fundamental ethical value. The concept is of particular relevance in the context of the human rights.\textsuperscript{64} The concept of dignity is regarded as 'inherent' and provides the basis and justification for inalienable human rights. Human dignity is of course invoked by both those in favour of, and opposed to, assisted dying.

Human rights law instruments, most recently the UN Convention on the Rights of Persons with Disabilities endeavour to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity. The Policy Memorandum refers to the concept of securing a "dignified death". In pursuing this aim, it is important to take into account the social model of disability and the concept of human dignity. For example, it cannot be said that a person affected by a loss of, or lack, of autonomy necessarily live a less dignified life than one who is capable of a higher degree of autonomy. In a more general sense, this does not mean that human dignity cannot be violated. In other words, autonomy could be restricted without affecting human dignity (which is inalienable).\textsuperscript{65}

Baroness Campbell has highlighted the risk associated with such decisions related to the lives of people with disabilities:

“\textit{Society today still discriminates against people with severe disabilities and illnesses. Our lives are seen by many as inferior to those of non-disabled people.}"

\begin{itemize}
\item\textsuperscript{61} Ibid 11. See also Thlimmenos v. Greece
\item\textsuperscript{62} Pretty v UK, para. 89.
\item\textsuperscript{63} See SHRC Strategic Plan available at http:\texttt{www.scottishhumanrights.com}
\item\textsuperscript{64} See for example \textit{Pretty v UK} at para 65
\item\textsuperscript{65} See for example Art 5 of the CRPD (prohibition of discrimination on the basis of disability); The Offences (Aggravation by Prejudice) (Scotland) Act 2009.
\end{itemize}
Against this background, there is the inherent danger that actions to withdraw treatment and legalized assisted dying will place disabled people at greater risk.‖

Assisted suicide and autonomy

Autonomy is a central value in human rights law and healthcare ethics. In case law, autonomy rights appear, at times, to be prioritised over other interests. However, the concept of autonomy is not absolute and it can be outweighed on the facts by the principles of fundamental justice. The ECtHR has clarified that: “the more serious the harm involved the more heavily it will weigh in the balance considerations of public health and safety against the countervailing principle of personal autonomy.”

Therefore, neither autonomy or choice can function as the sole criterion or overriding principle in the proposed legislation.

The values of autonomy and dignity are central issues which must be carefully considered in conjunction with other rights.

c) The need for clarity:

In the current criminal legal system

The criminalisation of assisted suicide is considered by the ECtHR to be an interference with an individual’s right to respect for private life under article 8(1) of ECHR, and so it must be justified on the grounds of Article 8 (2). In order to be compatible with the first ground in Article 8(2), the prohibition must be i) identified and established in the law of Scotland; ii) adequately accessible; iii) sufficiently foreseeable.

In Scotland, there is no statutory law that answers the question of whether it is criminal to help another person to commit suicide. This has always been considered a matter of common law. Euthanasia, however, is a criminal offence under the revised Code of Practice relating to Part 5 (Medical Treatment) of the Adults With Incapacity (Scotland) Act 2000. According to these provisions, the Crown Office and Procurator Fiscal Service can opt to charge the assister on a number of criminal grounds such as recklessly endangering human life, murder, culpable homicide, or can choose to bring no charge at all.

In Purdy v DPP, the House of Lords considered the Convention principle of legality. This principle “requires the court to address itself to three distinct questions. The first is whether there is a legal basis in domestic law for the restriction. The second is whether the law or rule in question is sufficiently accessible to the individual who is affected by the restriction, and sufficiently precise to enable him to understand its scope and foresee the consequences of his actions so that he can regulate his conduct without breaking the law. The third is whether, assuming that these two requirements are satisfied, it is nevertheless open to the criticism that it is being applied in a way that is arbitrary because, for example, it has been resorted to in bad faith or in a way that is not

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67 See for example the UN Convention on the Rights of Person with Disabilities
68 Re T (Adult: Refusal of medical Treatment) (1992) 9 BMLR 46
69 Pretty v UK at para 74
70 Niall R. Whitty and Murray Earle ‘Reissue Title on ‘Medical Law’ in (eds) The Laws of Scotland, Stair Memorial Encyclopaedia (Butterworths Law (Scotland), 2006), para 384
proportionate.

In that case the House of Lords’ overriding concern was the lack of clarity in prosecutorial policy. This signalled that the law in England and Wales, as it stood, was in violation of Article 8 of the ECHR.

It is possible to imagine a Purdy-style challenge being brought in Scotland since at present there is no way of knowing how the prosecuting authorities might respond to a relative who assisted the death of an individual. The concern is the lack of sufficient foreseeability. In order to be sufficiently foreseeable, there must be a sufficient degree of clarity in the law and its application. The law should be formulated with sufficient precision to enable the individual, if need be with appropriate advice, to regulate her conduct.

For this purpose and until a policy, including legislative, change in Scotland has been achieved, the Commission considers that the head of the prosecution service in Scotland, the Lord Advocate, should issue interim guidelines to further clarify the position for the public in relation to the prosecution of assisted suicide.

In the assisted suicide procedures

The current European experience shows that it is also important to ensure clarity in procedures where states do permit assisted suicide. Thus, legislation must take appropriate measures to protect abuse and to ensure that procedures are put in place which are capable of ensuring that a person’s decision to end his/her life does in fact reflect his/her free will. As mentioned legislation must also ensure clarity as to the extent of the right to assisted suicide, to prevent anguish caused by uncertainty.

3. Conclusions

The Assisted Suicide (Scotland) Bill has an impact upon some of the most fundamental elements of the dignity and autonomy of individuals and their families. Recognising the complexity and sensitivity of the topic the Commission has restricted itself at present to outlining the human rights framework within which determinations on whether to adopt legislation permitting assisted death may be made. In this respect, the Commission also emphasised a human rights based approach to this subject whereby the general policy framework should ensure adequate and comprehensive care and support for people with disabilities as well as palliative care for the terminally ill across the NHS in Scotland. Finally, The Commission addressed the need for greater clarification in prosecutorial policy.

On this point, the principle of legality under the European Convention on Human Rights calls for the law to be foreseeable. In the Commission’s view there is a strong case for increased clarity in the law of Scotland on the criminalisation of assisted suicide in Scotland, following the decision of the House of Lords in Purdy v DPP.

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71 R (on the application of Purdy) v the Director of Public Prosecutions [2009] UKHL 44, para 40
72 In addition, the Commission is also concerned that there is a lack of guidance relating to the omission doctrine, whereby doctors may withdraw life sustaining treatment in the certain knowledge that this will bring about the death of the patient. So, adults and in some cases children with incapacity may still lawfully be brought to an end. The Bill is silent on this. The commission finds this area requiring further clarification.
73 Hasan and Chaush v Bulgaria (2000) 34 EHRR 1339, para 84
74 the Director of Public Prosecutions (DPP) for England & Wales has issued similar guidelines in February 2010.
About the Commission: The Scottish Human Rights Commission is a statutory body created by the Scottish Commission for Human Rights Act 2006. The Commission is a national human rights institution (NHRI) and is accredited with ‘A’ status by the International Co-ordinating Committee of NHRI s at the United Nations. The Commission is the Chair of the European Network of NHRI s. The Commission has general functions, including promoting human rights in Scotland, in particular to encourage best practice; monitoring of law, policies and practice; conducting inquiries into the policies and practices of Scottish public authorities; intervening in civil proceedings and providing guidance, information and education.

Scottish Human Rights Commission
20 October 2014
Submission from Police Scotland

Police Scotland acknowledges the complex ethical considerations surrounding this Bill and the considerable debate over the moral, religious and cultural aspects of it. It would not be appropriate for Police Scotland to enter the ethical debate or to provide opinion on whether or not a person should be able to request assistance to commit suicide.

The question of the legality of the proposed measures is a matter for the Scottish Parliament and Crown Office and Procurator Fiscal Service. The way in which assistance could be provided with the related medical and psychological considerations is a matter for the medical profession. In the event the Bill was to become law, Police Scotland would follow guidelines issued by the Lord Advocate.

The police currently investigate and report to the Procurator Fiscal all:

- Sudden or accidental deaths
- Suicides
- Deaths which have occurred in suspicious circumstances
- Deaths for which a medical practitioner declines to issue a death certificate
- Deaths arising at or in connection with employment: and
- Deaths in respect of which the Procurator Fiscal requests a report

Assisted Suicide (Scotland) Bill – Explanatory Notes

- Costs on other bodies, Individuals and businesses

Police Scotland and Crown Office and Procurator Fiscal Service (COPFS)

Paragraph 30 outlines ‘Every assisted suicide (or attempt) must be reported to the Police. It will be for the police to decide whether the Bill has been properly complied with. In most cases, this should be a straightforward matter, as there will be a clear set of documented evidence (signed and endorsed preliminary declaration, first and second requests etc), and there should normally be a facilitator who can provide any further information that may be required (including about the circumstances of the death itself). Only if there is reason to believe that the new law has been breached would it be necessary for the police to carry out more extensive investigations and, where appropriate, refer the case to the Procurator Fiscal’

If the Bill were enacted there may be an increase in the overall number of investigations carried out by the police as a result of additional enquiries into deaths where suicide assistance has been provided. Each stage of the process would have to be evidenced as having been lawfully undertaken. Any investigation into a suspicious death is protracted and resource intensive.

Assisted Suicide (Scotland) Bill – as Introduced

- Section 20 – Reporting to Police

Section 20 sets out the circumstances in which a licensed facilitator is under a duty to report the person’s death or attempted suicide to the police.
The potential for an enquiry to be instigated for any death where there is any accusation or uncertainty over the meeting of the Bills eligibility conditions needs to be considered including clarity over recording, monitoring and accountability, which Police Scotland considers is still not fully addressed in the current draft.

Comparison with End of Life Assistance (Scotland) Bill

It is noted that The Assisted Suicide (Scotland) Bill removes the words “finds life intolerable” which was within the 2010 proposed End of Life Assistance (Scotland) Bill. This was highlighted as a concern previously by the then Association of Chief Police Officers (Scotland) (ACPOS) as medical practitioners may have had different interpretations. It is further noted that many of the ACPOS points made within their original response made to the earlier Bill have been addressed within the content of the current Bill and these changes are welcomed by Police Scotland.

Method

The Bill does not specify what methods are available for ending the life of the requesting person although within the associated Policy Memorandum the provision of prescribed drugs by a medical practitioner is envisaged as being the normal method used. The Policy Memorandum, however, does contain comment that the “Bill is drafted widely enough to allow for the use of other substances or means, should those be preferred or become available”. It is suggested that consideration is given to providing further detail around method, means and recording.

Role of Licensed facilitators

The information contained in the Bill relevant to the role of the licensed facilitators is fairly general. Reference is made to opportunities to make subordinate legislation, which are delegated to Scottish Ministers. These powers cover the ‘Appointment of the Licensing Authority’ and ‘Maintenance of Standards Amongst Licensing Authorities and Facilitators and Procedural Matters’. The nature of the role and the conduct of the licensed facilitator is core to ensuring compliance with the requirements of the Bill. Police Scotland would welcome any future opportunity to contribute to the development of Regulations governing all aspects of the operation of the relevant licensing scheme, including the maintenance of written records by facilitators and how, if acting alone with the person at the time of the assisted suicide, they would be legally protected if there was a subsequent allegation of impropriety.

Insurance Implications

Life Insurance policies may require further consideration given many insurers will not pay out if the policy holder commits suicide in the first 12 months of the policy or there has been non-disclosure about medical or psychiatric treatment.

Police Scotland works closely with our partners to prevent suicide in line with the Scottish Government’s National Suicide Prevention Strategy (2013–2016). The strategy, which commits to continue the downward trend in suicides and contributes to the delivery of the National Outcomes to enable people to live longer healthier lives, also forms the policy developed alongside the National Programme for the Improvement of Mental Health and Wellbeing in Scotland.

While I acknowledge the widespread discussions on going in terms of proposed
legislation change, Police Scotland continues to work within the present legislative framework and investigates sudden deaths, as directed by the Procurator Fiscal, which includes occasions where information or evidence suggests a criminal offence may have been committed.

I hope the above is of some assistance.

Deputy Chief Constable Iain Livingstone
Police Scotland
Submission from the Lord Advocate

It is recognised that this is a particularly difficult and emotive area of law raising important issues and therefore it is quite proper that any proposed change should be a matter for the Scottish Parliament. To assist the Committee in its deliberations, it might be helpful for me to explain the current position in Scotland where a person assists another to die.

As the Committee will be well aware due to historical differences between Scotland and the rest of the United Kingdom the development of legal systems in Scotland have resulted in a quite distinct criminal law in most instances except for where there has been law made by legislation of the UK Parliament which expressly covers Scotland.

Suicide is not a crime known to Scotland, nor is there a distinct crime of assisted suicide. In contrast, there is a statutory offence in England and Wales of assisted suicide in terms of section 2 of the Suicide Act 1961. The Suicide Act 1961 does not apply in Scotland.

In Scotland, if someone assists another to take their own life, such cases would be reported to the Procurator Fiscal as a deliberate killing of another and thus dealt with under the law relating to homicide.

Under the law of homicide, it would have to be considered whether there was sufficient evidence to establish that a crime had been committed, that the accused was the perpetrator and that the accused had the requisite mens rea (intention) to commit the offence.

In order to be satisfied that a crime had been committed the Crown would have to consider that there was a direct causal link between the actings of the accused and the deceased’s death. In other words, that it was a significant contributory factor to the death. There is a considerable amount of case law in Scotland dealing with the issue of causation, which would require to be carefully considered in light of the circumstances of each case.

Thereafter consideration would have to be given to whether prosecution is in the public interest. The criteria for deciding whether prosecution is in the public interest are set out in the COPFS Prosecution Code. I am sure that you will appreciate that there is a high public interest in prosecuting all aspects of homicide where there is sufficient, credible and reliable evidence.

If the Crown considers there to be sufficient evidence that a person has caused the death of another it is difficult to conceive a situation where it would not be in the public interest to raise a prosecution but each case would be considered on its own facts and circumstances.

Thereafter it would be a matter for a jury to consider whether they were satisfied to the criminal standard of proof that the accused was guilty of homicide and also being satisfied that there was a direct causal link between the accused’s actions and the deceased’s death. It would also be for the court to decide the appropriate sentence taking into account any mitigatory factors that exist.
I hope that this letter will be of assistance to the Committee in its work. I am content that this letter be made public.

Frank Mulholland QC
Lord Advocate
Introduction

1. The Justice Committee will consider the Road Traffic Act 1988 (Prescribed Limit) (Scotland) Regulations 2014 at its meetings on 28 October and 4 November.

2. The purpose of the regulations is to provide for the drink drive limit in Scotland to be lowered from 80 milligrams (mg) of alcohol in 100 millilitres (ml) of blood to 50mg of alcohol in 100ml of blood, and for equivalent changes to be made to the limits for the concentration of alcohol in breath and urine. The changes are due to come into force on 5 December.

3. Further details on the purpose of the instrument can be found in the policy note at Annexe A to this paper. A hard copy of the instrument is included with the papers and can also be accessed at following link: http://www.legislation.gov.uk/sdsi/2014/9780111024478/contents

4. The instrument is subject to the affirmative procedure and the Committee is required to report on it to the Parliament by 20 November.

Committee scrutiny

5. In order to inform its scrutiny of the proposals, the Committee agreed to take evidence in advance of formally considering the legislation. Representatives from Police Scotland, Scottish Health Action on Alcohol Problems (SHAAP) and Scotland’s Campaign against Irresponsible Drivers (SCID) will give evidence at the meeting.

6. The Cabinet Secretary for Justice will then attend the meeting on 4 November where the Committee will formally consider the instrument.

7. The responses from SCID and SHAAP to the Scottish Government’s consultation on the proposals are attached in Annexe B. The consultation pre-dates the establishment of Police Scotland and so the response to the consultation on behalf of the police is in the name of ACPOS. However, Police Scotland has confirmed that it endorses this submission which is also attached at Annexe B.

8. The Institute for Advanced Motoring and Brake were invited to attend but were unavailable. Their submissions are also provided at Annexe B as background.
Introduction

1. The above instrument was made in exercise of the powers conferred by sections 8(3) and 11(2) of the Road Traffic Act 1988 as amended by section 20 of the Scotland Act 2012. The instrument is subject to affirmative procedure.

Policy Objectives

2. These regulations provide for the “drink drive” limit to be lowered from 80 milligrams (mg) of alcohol in 100 millilitres (ml) of blood to 50mg of alcohol in 100ml of blood, and for equivalent changes to be made to the limits for the concentration of alcohol in breath and urine.

3. The regulations amend the “prescribed limit” set out in section 11(2) of the Road Traffic Act 1988 which sets out the limits on the proportion of alcohol present in the breath, blood and urine. The new limits are 50mg/100ml of blood, 22 micrograms/100ml of breath and 67 mg/100ml of urine. The regulations also make a consequential amendment to section 8(2) of the Road Traffic Act 1988 to reduce the limit below which a person can elect to have a specimen of breath replaced with a specimen of blood or urine (the so-called “statutory option”) which is currently available to drivers whose breath/alcohol level is found to be over the prescribed limit, but less than 50mcg/100ml of breath. The order provides that the “statutory option” will be available to drivers whose breath/alcohol level is less than 31mcg/100ml.

4. The Scottish Government believes that this will help to make Scotland’s roads safer. On average, just over one in eight deaths on Scotland’s roads in recent years involve drivers over the legal limit. That is an average of 30 deaths each year.

5. Estimates of how many lives can be saved with a lower limit vary, but there is evidence that indicates between three and 17 lives each year could be saved on Scottish roads from a lower limit of 50mg/100ml.

Background

6. The Scotland Act 2012 provides the Scottish Ministers with a power to amend the “prescribed limit” for the concentration of alcohol in a driver’s blood, breath or urine for the purpose of driving, attempting to drive or being in charge of a vehicle in Scotland. In short, this means that the Scottish Ministers have a power to change the “drink drive” limit.

7. In 2012, the Scottish Government undertook a public consultation\(^1\) on a proposal to lower the drink-drive limit from 80mg/100ml of blood to 50mg/100ml of

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\(^1\) http://www.scotland.gov.uk/Publications/2012/09/3556
blood, which would bring Scotland into line with most of Europe. The responses to the consultation were analysed and showed that almost three quarters (74 per cent) of respondents to believe that drink drive limits should be reduced.

8. In 2009, the then UK Government commissioned an independent review of drink and drug driving law. For this purpose, the North Review Committee, led by Sir Peter North CBE QC, was established and they published their recommendations in the summer of 2010\(^2\). The North Report of the Review of Drink and Drug Driving Law indicated that a lower drink limit of 50mg of alcohol in 100ml of blood would help save lives.

9. Paragraph 4.12 of the North Report noted that evidence showed drivers are six times more likely to die with a blood alcohol concentration level between 50 and 80mg/100ml than with zero blood alcohol. Evidence submitted in 2010 by the British Medical Association to the House of Commons Transport Committee's inquiry into drink and drug driving law indicated that the relative risk of being involved in a road traffic crash for drivers with a reading of 80mg of alcohol per 100ml of blood was 10 times higher than for drivers with a zero blood alcohol reading\(^3\). The relative crash risk for drivers with a reading of 50mg of alcohol per 100ml blood was twice the level than for drivers with a zero blood alcohol reading.

10. Paragraph 4.17 of the North Report went on to state:
   “The estimates of the potential for a lower limit of 50 mg/100 ml to save lives vary. On the one hand, Professor Richard Allsop estimates, with conservative assumptions, that 43 lives could be saved in Great Britain annually, NICE on the other hand makes more ambitious estimates, based on the experience of research conducted in Europe and in Australia. NICE applies their model to all road traffic casualties in England and Wales rather than just those reported as drink drive-related. Based on the Albalate study of European countries, although without a defined time horizon, 77 – 168 lives could be saved each year in England and Wales whereas, based on the Australian experience, 144 lives could be saved after the first year in England and Wales, progressively increasing by the 6th year to a total of up to 303 deaths avoided.

   These estimates for England and Wales take no account of the possible casualty savings for Scotland. It should be noted that Scotland represented 7% of all drink drive-related casualties in Great Britain in 2008”.

11. As can be seen, a range of studies are mentioned in the North Report and an analysis applied to England and Wales figures. Apportioning these figures to Scotland would suggest a range of between 3 and 17 fewer deaths per year would result following the introduction of a lower drink drive limit.

\(^3\) http://www.publications.parliament.uk/pa/cm201011/cmselect/cmtran/460/460we12.htm
Consultation

12. A Scottish Government consultation was undertaken to hear views on a proposal for a lower limit. In addition to wanting to receive feedback on the proposals, the need for the Scottish Government to consult is a requirement under section 195(2A) of the Road Traffic Act 1988 before a legislative change to change the drink drive limit can be introduced. The Scottish Government undertook the public consultation on proposals to lower the drink-drive limit between September 2012 and 29 November 2012. The consultation analysis revealed that 74% of those who responded to the consultation agreed that the drink drive limit should be reduced, and of those, 87% agreed with the Scottish Government’s proposal to lower the blood alcohol limit from 80mg/100ml to 50mg/100ml.

13. The consultation responses suggested the likely benefits of a lower limit would be fewer road accidents and fewer casualties. A number of respondents also called for the Scottish Government to be given further powers by the UK Government to tackle drink driving including, for example, powers enabling the police to undertake random breath testing, and lower drink-drive limits for young and newly qualified drivers, or professional drivers such as HGV, bus or taxi drivers.

14. A full list of those consulted and who agreed to the release of this information is attached to the consultation report published on the Scottish Government website at http://www.scotland.gov.uk/Publications/2013/03/6912.

Impact Assessments

15. Equality Impact Assessment (EQIA) is a tool to assist in considering how policy (by policy we mean activities, functions, strategies, programmes and services or processes) may impact, either positively or negatively, on different sectors of the population in different ways.

16. We have considered the impact of policy on particular groups of people (whatever their age, race, gender, sexual orientation, religion or belief or whether disabled or not). We are not aware of any evidence that any of the equality strands will be affected by the lowering of the drink-drive limit.

Financial Effects

17. A Financial Note has been completed, setting out the financial implications of lowering the drink-drive limit for the Scottish Administration and for other bodies, individuals and businesses.

Scottish Government
Justice Directorate
September 2014
Submission from Scottish Health Action on Alcohol Problems

1. Do you agree that the drink drive limits should be reduced in Scotland?

Yes

1A. The Scottish Government is proposing:

- A reduction in the blood limit from 80mg of alcohol in every 100 ml of blood to 50 mg of alcohol in every 100 ml of blood;
- An (equivalent) reduction in the breath limit from 35 mcg of alcohol in 100 ml of breath to 22 mcg of alcohol in every 100 ml of breath; and
- An (equivalent) reduction in the urine limit from 107 mg of alcohol in 100 ml of urine to 67 mg of alcohol in every 100 ml of urine.

Do you agree with the SG proposal to reduce the drink driving limits?

Yes

Yes, SHAAP agrees with the proposal to reduce the drink driving limits. There is compelling evidence (for example, from the Institute for Alcohol Studies) to suggest that a reduction in the limits would make a positive impact in terms of reducing road traffic accidents and road traffic deaths.

2. Do you have any evidence for what would be the main consequences of the SG proposals?

Given the evidence presented by the Institute of Alcohol Studies (Alcohol and Drink Driving, 2010) that drinking by drivers with blood alcohol levels of between 50mg% and 80mg% was a significant but largely hidden cause of accidents, SHAAP anticipates that the new lower limit would be extremely beneficial.

4. Do you have any comments to make on the ancillary matters related to the SG’s proposal to reduce the drink drive limits?

No comments.

5. Are there any other measures that should be considered in order to tackle drink driving?

SHAAP considers that there are a range of other options that might be considered in order to tackle drink driving. These include:

Making it clear that even the smallest amounts of alcohol will impair the considered in order to tackle drink driving. These include:

- Making it clear that even the smallest amounts of alcohol will impair the function to drive. Giving some more specific examples of how your ability to
drive safely is compromised might be helpful as would reviewing relevant medical evidence;

- Supporting a campaign to discourage drinking at any level whilst driving – given that people metabolise alcohol at varying rates it is almost impossible to advise people on what they can and cannot drink before driving. We note that there are a small number of EU countries with a zero level for drink driving;

- Targeting specific groups of drivers. Evidence from the consultation document points to younger drivers being affected by alcohol more than older drivers. According to the Institute of Alcohol Studies the peak age for drink driving is 27. The same report also suggests that nine out of ten drink drivers are men;

- We note from evidence presented in the consultation documents that a small number of countries have different drink drive limits for private motorists and commercial drivers (for example drivers of public transport and heavy goods vehicles) and wonder whether it would be worth considering something similar in Scotland;

- Primary prevention and education activities, especially for young people;

- Comprehensive access to support and treatment services for people with alcohol problems and;

- Support for families affected by alcohol misuse, including drink driving;

- Random and selective breath-testing of drivers should be introduced.

- Any driver who commits a drink driving offence might only be permitted to drive a vehicle fitted with an ‘alco-lock’.

- Graduated licensing should be introduced, restricting the circumstances in which novice drivers can drive.

- ‘Zero tolerance’ for novice drivers, drivers of commercial vehicles and drivers of motorbikes.
Submission from ACPOS (endorsed by Police Scotland)

1. Do you agree that the drink drive limits should be reduced in Scotland?

Yes

1A. The Scottish Government is proposing:
   - A reduction in the blood limit from 80mg of alcohol in every 100 ml of blood to 50 mg of alcohol in every 100 ml of blood;
   - An (equivalent) reduction in the breath limit from 35 mcg of alcohol in 100 ml of breath to 22 mcg of alcohol in every 100 ml of breath; and
   - An (equivalent) reduction in the urine limit from 107 mg of alcohol in 100 ml of urine to 67 mg of alcohol in every 100 ml of urine.

Do you agree with the SG proposal to reduce the drink driving limits?

Yes

Whilst in principle this seems to be appropriate, clarification requires to be obtained from an authoritative source as per the Home Office Centre for Applied Science and Technology (HO CAST) with regards to the exact equivalent enforcement levels for breath and urine samples based on the proposed 50 microgram (mg) limit for blood.

2. Do you have any evidence for what would be the main consequences of the SG proposals?

   - Different road traffic laws across the UK may be confusing to road users especially tourists. There is currently a great deal of ignorance surrounding how much alcohol a driver can consume and still remain below the current threshold. By reducing this limit drivers will need to think much more carefully about drinking any alcohol whatsoever and will therefore assist in a reduction in the number of drivers testing positive.

   - It is hoped that a reduction in the drink drive limit would see the number of persons injured on our roads decrease. This will assist us in attempting to achieve the targets set out in the Scottish Road Safety Framework to 2020.

   - Whilst there is no evidence to support the following view there is every probability that a reduction in the limit would bring about more convictions for drink driving, more vehicle seizures/confiscations, and undoubtedly more 'morning after' detections.

   - It must be considered that at the present time there is an indeterminate number of drivers who will be driving whilst they have consumed a quantity of alcohol which, if they were required to provide a specimen of breath, would be ‘under’ the current prescribed limit but with the introduction of the revised limit will then be “over” the enforcement level. Thus a greater number of offenders will have to be dealt with at all stages by the police, procurator fiscal and court services.
• It follows in such circumstances there will be more persons arrested, who then have to be transported to and processed at a police station custody suite and thereafter be detained in custody until they provide a negative breath test. This will undoubtedly increase the pressure of work on custody suites and in prisoner care issues. The implementation of a lower limit may therefore impact upon remaining resources to deal with other matters.

• This position may be accentuated in more rural areas where personnel may have to travel extended distances to convey suspects to custody suites where Intoximeter ECIR evidential devices are located. If the roadside test is ‘border-line’ it could be that the accused provides a subsequent evidential sample which is below the revised enforcement thresholds or alternatively within the range for the application of the ‘statutory option’. In the latter case this may extend the working procedures and potentially increase the number of occasions where Medical Practitioners or Registered Health Care Professionals are required to take blood for laboratory analysis.

• In fairness to the driving population, this particular impact of the reduction will require to be well publicised in the media.

3. Do you have any evidence for what would be the financial impact of the SG proposals?

During a significant and prolonged period of austerity the financial impact may include a wide range of factors. The financial impact on the individual detected will continue to be significant with loss of vehicle, higher insurance premiums and possible loss of employment, etc.. In terms of the wider economy, there may be a potential impact on tourism and the licensing trade.

If the reduction in the limit reduces the number of injuries on the road as a result of crashes then this will have a positive financial impact on many public services of the country including, the Police, Fire & Rescue Services, Scottish Ambulance Service and NHS Scotland as well businesses and commerce.

We would expect an increase in the number of people who may be applicable for the forfeiture scheme (dependent on any changes to the Lord Advocate’s Guidelines), which may increase the workload for the partner agencies involved in this. There are potential implications for any revision to the current drink drive enforcement thresholds with regard to technical issues associated with Home Office Type Approval (HOTA) for both roadside screeners and station evidential devices. Depending upon the advice received there may be significant financial implications for the Scottish Police Service if there is any requirement to alter current devices or purchase replacement devices. It is also envisaged that there may be development costs for device manufacturers.

This may be an opportune time to procure and instigate the use of Data Enabled Breath Test Devices by the Police Service of Scotland which would provide the much desirable accurate analytical evidence on the levels of drink driving.
Linked to any device/procedure changes, there will be re/training requirements hence resource implications and training costs. As well as amendments to existing police drink drive procedural forms and Force guidance manuals/operating procedures.

4. Do you have any comments to make on the ancillary matters related to the SG’s proposal to reduce the drink drive limits?

Border Issues
There are not signs on every road which enters Scotland telling motorists if they have entered Scotland or vice versa. Currently the majority of road traffic laws are the same in across the UK therefore every motorists does not necessarily need to take heed of the border signs as the offence they are committing in England is likely to be the same in Scotland.

This is a radical change, Scotland specific, which is being proposed. It would therefore be crucial to inform all motorists of when they are entering Scotland. The situation could arise for a motorist who was stopped for drink driving in a bordering village such as Gretna Green to claim that they thought they were still in England. There would obviously be financial implications for the Scottish Government/Local Authorities to position “Welcome to Scotland” signs on all roads entering Scotland but this may be a legal requisite.

As already stated there would need to be a significant educational media campaign carried out and not just in Scotland prior to the introduction of this reduction to ensure those living near to the Border were aware of any legislative reductions.

Forfeiture Scheme
In relation to Vehicle Forfeiture procedures, the current classification of a “high reader” is someone who provides a sample of 3 or more times above the prescribed limit, which would currently be 105ug of alcohol in 100 millilitres of breath and above. If the ratio of 3 times and above were to remain following a successful implementation of the new limit of 22ug of alcohol in 100 millilitres of breath, then a reading of 66ug and above would be identified as a “high reader”. At this level the number of vehicle seizures pending forfeiture would increase dramatically as currently a reading of 66ug and above would not be uncommon. This could also cause potential problems within Police Custody centres who are instructed by the Lord Advocated Guidelines to hold such offenders in custody pending their initial court appearance.

As a result, the current forfeiture criteria/thresholds may require to be reviewed in relation to a reduced drink drive limit.

Statutory thresholds and options
At present where an offender provides a breath specimen at a Police station of 39ug or less, no further action is taken unless there is further impairment is suspected. Will there continue to be a similar ‘tolerance threshold’ i.e. will this figure be reduced by the same ratio as the limits or will this be removed completely?
Currently when an offender provides a breath specimen of more than 39ug but no more than 50ug they are given the option of having the breath specimen replaced by a blood or urine sample. Again will this be reduced by the same ratio or be removed? It could be argued that the Road Traffic Act 1988 was drafted and enacted in a time when the HOTA evidential devices did not have the same level of accuracy as the current evidential devices and therefore the ‘statutory option’ allowed for a more accurate result to be obtained in these circumstances in fairness to the accused.

The potential advent of a reduction of the drink drive limit would appear to be an opportune time to revisit these debatably ‘out-dated’ thresholds and options which in turn would reduce costs in terms of police officer time, Force Medical Examiners call out, COPFS processes and laboratory analysis.

5. Are there any other measures that should be considered in order to tackle drink driving?

**Further legislative powers**
Currently, the law provides that a police constable in uniform may stop a vehicle for the purpose of establishing the validity of driver and vehicle documentation.

The provision in law for a constable to be able to stop a vehicle on a road or public place to establish whether or not the driver, or a person who is accompanying a provisional licence holder, is not over the prescribed limit, would greatly assist the detection of drivers putting the own life and that of road users by drink driving which in turn would help reduce road causalities and make Scotland’s roads safer.

Any legislation proposed along this line should also be future-proofed to allow the stopping of a vehicle for an existing Preliminary Impairment Test (PIT) to be carried out or, the use of any future type approved device which would be used to determine drugs impairment.

Alcohol is known to effect younger drivers more strongly than older drivers, as per the European Commissions recommendations in 2001 that a blood alcohol limit of 20 milligrams of alcohol per 100 millilitres of blood should be the limit for professional and new drivers. Consideration could be given to introducing this lower limit at the same time.

**Education and Media Campaign**
During the 1980s/90’s a long and sustained advertising campaign successfully changed the social attitude to drink driving to one where it was socially unacceptable with a drink driving conviction carrying a significant social stigma with it.

This message is now usually only pushed during the festive period and it would appear that the social stigma is no longer as prevalent as it once was. This would appear to particularly be the case with young drivers who are too young to remember the advertising campaigns of the 80s and 90s. The experience of the past would suggest that a sustained campaign aimed at raising awareness and changing social attitudes would be the most effective way of reducing drink driving.
The reduction of the drink drive limit would provide the ideal opportunity to kick start such an initiative assisting to ensure maximum impact and effectiveness.

A new and full programme of education will be required if the proposal to reduce the current limit were successful. Engagement with the Licensed Trade and alcohol manufacturers should also be considered. Consideration could be given to enhancing education in an effort to dissuade offenders and encourage public support.

Other possible measures
Consideration of creating drink driver courts (dedicated courts on specific days with trained PF’s and Sheriff’s that are aware of the impact of drinking and driving).

Association of Scottish Police Superintendents
Submission from Scotland’s Campaign against Irresponsible Drivers

SCID applauds the Scottish Government’s commitment and persistence to tackle the scourge and misery that drink drivers not only bring upon themselves and their families but more importantly to the innocent road users that have become and continue to become victims of such driving. We understand that the Scottish Government’s powers are restricted under the devolved powers in the Scotland Act 2012 and the proposed reduction in the drink drive limit is, at present, all that is on offer. The evidence for additional measures in tackling drink/drug driving is overwhelming and it is to be expected that the Scottish Government will continue to press for more powers to do so.

1. Do you agree that the drink drive limits should be reduced in Scotland?

Yes

1A. The Scottish Government is proposing:

- A reduction in the blood limit from 80mg of alcohol in every 100 ml of blood to 50 mg of alcohol in every 100 ml of blood;
- An (equivalent) reduction in the breath limit from 35 mcg of alcohol in 100 ml of breath to 22 mcg of alcohol in every 100 ml of breath; and
- An (equivalent) reduction in the urine limit from 107 mg of alcohol in 100 ml of urine to 67 mg of alcohol in every 100 ml of urine.

Do you agree with the SG proposal to reduce the drink driving limits?

Yes

2. Do you have any evidence for what would be the main consequences of the SG proposals?

- At a Scottish level SCID is only too aware of the devastation caused by drink/drugged drivers. Such road deaths and injuries have a far reaching social cost together with emotional, practical and financial consequences. The main consequence of the Scottish Government’s proposals would be to spare the grief currently being experienced by victims and bereaved families to other road users.

- Scottish Governments proposals would see a reduction in the number of deaths and serious injuries caused by drivers who ignore the law and drive whilst impaired by alcohol. This in turn would reduce the economic cost$^4$, including savings in resources and deployment of police,

$^4$ Reported Road Casualties in Great Britain: http://assets.dft.gov.uk/statistics/releases/road-accidents-and-safety-annual-report-2011/rcgb2011-02.pdf states: The total value of prevention of reported UK road collisions in 2011 was estimated to be £15.6 billion. Prevention can be interpreted in two ways here: on the one hand, it is the benefit which would be obtained by prevention of road crashes from a cost benefit view point. On the other hand, it can be considered as the loss to society due to the current level of road accidents. This includes an estimate of damage only accident costs
emergency services, NHS and in appropriate cases, court and associated costs and sentencing.

- We endorse and recommend, to this consultation, the policy paper published in April 2012 by the European Transport Safety Council (ETSC) *Drink Driving towards Zero Tolerance*. This paper provides a comprehensive overview of the drink driving situation in the European Union and measures taken at the EU level to curb drink driving deaths. The ETSC called on Member States and the European Institutions to adopt a zero tolerance for drink driving. Other ETSC recommendations to Member States and the European Union are also included. This comprehensive paper looked at countries’ progress in reducing road deaths attributed to drink driving between 2001 and 2010. Southern Ireland achieved impressive reductions in cutting alcohol related deaths from 124 in 2003 to 48 in 2007. Slovakia cut drink driving deaths from 50 in 2001 to an average of 15 per year in 2008-2010. Latvia, Bulgaria, Hungary, Sweden, Slovenia, Lithuania, Germany, Belgium, Greece and Austria also reduced drink driving deaths faster than other road deaths. Finally the paper presented a case study of four European countries: the Czech Republic, Ireland, Norway and Sweden. Successes and shortcomings of drink driving policies are discussed with national experts from these four countries. The implementation of alcohol interlocks in Norway, the adoption of a lower BAC (blood alcohol concentration) limit in Southern Ireland, the effect of zero tolerance for drink driving in the Czech Republic and the impact of Vision Zero to support the fight against drink driving in Sweden are among the good practices implemented in those countries.

- As the Scottish Government’s research shows; within the EU; UK and Malta have the highest BAC of 80mg/100ml. What the ETSC paper shows that EU countries who have adopted a lower BAC have significantly reduced alcohol related road deaths and it is to be assumed by default serious injuries also. It is worth noting that a number of the EU countries have a lower BAC of 20mg/100ml for commercial drivers.

3. Do you have any evidence for what would be the financial impact of the SG proposals?

but does not take account of under-reporting of accidents. A number of assumptions have been made to produce a broad illustrative figure which suggests that allowing for accidents not reported to the police could increase the total value of prevention of road accidents to around £34.8 billion.

5 The European Transport Safety Council (ETSC) is an international non-governmental organisation which was formed in 1993 in response to the persistent and unacceptably high European road casualty toll and public concern about individual transport tragedies. ETSC brings together experts of international reputation and representatives of 45 national and international organisations concerned with transport safety from across Europe to exchange experience and knowledge and to identify and promote research-based contributions to transport safety. ETSC provides an impartial source of advice on transport safety matters to the European Commission, the European Parliament and, where appropriate, to national governments and organisations concerned with safety throughout Europe.


- The Scottish Government’s estimated financial impact of drink drive incidents is £80m. This figure does not include the cost of injury incidents; the cost of £300 million\(^8\) to the UK National Health Service, the cost of UK car crashes linked with drink driving or to associated legal costs, court costs and imposed penalties. The latest estimated cost of all road crashes is a staggering £34.8 billion.\(^9\) It is fair to say in Scotland that the estimated cost will be around 1/10\(^{th}\) of the UK figure i.e. ~£3.5 billion.

- It has been proven that a reduction in drink drive limit in other EU countries would have a huge reduction in the number of drink drive incidents and a huge reduction in the financial cost to the nation. What needs to be clarified and learned from; is by what means the drink drive laws are enforced in other EU countries. E.g. Random breath testing, effective use of penalties etc.

To make any law effective it has to be seen to be enforced. The risk of detection and full use of penalties has to be seen to outweigh the risk of drink driving. At present drink drivers have no fear of detection and even when some are; the court is very charitable in its leniency. E.g.

- “Three strikes and you’re out” is common place sentencing for those who are caught drink driving.

- A 19 year old driver ploughed a car into two BEAR Scotland workers, as they painted lines on a road leaving one victim fighting for his life. The youth had been drinking Buckfast with his brother and friend before driving through country roads even though none of them had a driving licence. Doctors giving evidence in court said the victim’s injuries appeared “unsurvivable” and if he did survive he would be left in a permanent vegetative state. The offender received a 13 month custodial sentence for which he would in practice serve half. The mother of the seriously injured victim said the sentence was “pathetic” as her son now required 24/7 care.

- Legislation for the seizure of vehicles for drink driving came under the Road Traffic Offenders Act 1988, which came into force in April 1996 and extended powers under THE ANTISOCIAL BEHAVIOUR (SCOTLAND) ACT (2004). In a bid to reduce the number of drink drivers ACPOS, law enforcement partners and the Scottish Government introduced a new drink drive initiative. First-time drink-drivers, who provide a sample for analysis which is three times the legal limit or more, and those who refuse a breath test, could have their vehicles confiscated and sold off, after conviction. That would be in addition to receiving a criminal record, a fine and a 12-month driving ban. In January 2012 a 51 year old male driver admitted driving whilst three times over the legal limit challenged a move by the Crown to seize his £23,000 car. The offender had collided with a car driven by an 81-year-old man at a roundabout. He was arrested at his home. On appearing at

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court the next day his solicitor has now told the court that forfeiture of the car
would be a “disproportionate punishment, given that the value of the car is
some £23,000.” The presiding sheriff said he didn’t regard granting an
application by senior fiscal depute for forfeiture of the offender’s high
powered Audi RS4 Quatro car as being “an appropriate or necessary thing to
do” and the accused was ordered to carry out 200 hours of unpaid work in the
community and banned from driving for two years and eight months. It is
obvious the sheriff valued the car more than the drunk driver who risked not
only damaging his car but risking his life and that of other innocent road
users. **Drink drivers will not take the law seriously if the courts do not.**

4. **Do you have any comments to make on the ancillary matters related to
the SG’s proposal to reduce the drink drive limits?**

- There is widespread support for a reduction in the drink drive limit; British
Medical Association\(^{10}\), Royal Society for the Prevention of Accidents\(^{11}\),
ACPOS\(^{12}\) and the Lord Advocate\(^{13}\). It beggars belief that the UK government’s
Select Committee did not adopt the recommendations in the North Report\(^{14}\)
including one of lowering the drink drive limit to 50 mg of alcohol in 100 ml of
blood and the equivalent amounts in breath and urine but instead opted for
concentration on “tougher enforcement”\(^{15}\) which they believed would be more
“cost effective”.

- While SCID would totally agree with tougher enforcement, this must go hand in
hand with a range of other measures including; a lower drink drive limit,
random breath testing and full use of the law. In risk assessment terms - It has
been proven that if the legal limit stands at BAC 80mg/100ml the risk of

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\(^{10}\) [http://bma.org.uk/news-views-analysis/news/2012/february/drink-driving-limit-demand](http://bma.org.uk/news-views-analysis/news/2012/february/drink-driving-limit-demand) - February 2012 - The association renewed its call to cut the permitted BAC (blood alcohol content) for motorists from 80mg/100ml to 50mg/100ml in a briefing to MPs ahead of a Commons road safety debate this week. The BMA states: ‘There is considerable evidence that driving impairment and crash risk increase exponentially with increasing BAC levels, and that lowering the prescribed limit changes driver behaviour and results in fewer serious and fatal crashes.’


\(^{12}\) Deputy Chief Constable Tom Ewing, secretary of Road Policing for the Association of Chief Police Officers in Scotland, said: “We welcome an opportunity to take part in a wide consultation on a reduction of the current drink drive limits. It has always been the position of ACPOS that drivers should not drink alcohol at all before getting behind the wheel but any lowering of the limit could lead to a reduction in those tempted to do so.”

\(^{13}\) Lord Advocate, Frank Mulholland QC, said: “As prosecutors we know from bitter experience the misery and suffering that driving under the influence can cause. It all too often results in serious injury or loss of life with around 10 per cent of the deaths on Scottish roads involving drivers who are over the legal limit.

\(^{14}\) Sir Peter North CBE QC - Independent North Review of Drink and Drug Driving Law; “A reduction to 50 mg/100 ml would undoubtedly save a significant number of lives. In the first year post-implementation, estimates range from at least 43 to around 168 lives saved – as well as avoiding a larger number of serious injuries – a conservative estimate is 280. At the other end of the range, avoiding as many as almost 16,000 injuries (including slight and serious) has been modelled.”

crashes and of crash injury, will be twice than at 50mg/100ml\textsuperscript{16}.

- SCID campaigns for a lower BAC of 20mg/100ml.
- Random breath testing.
- Zero limit for young and new drivers

5. **Are there any other measures that should be considered in order to tackle drink driving?**

To curb the culture of drink driving requires a range of measures.

- The courts must use their full powers in sentencing drunk/drugged drivers. All the legislation in the world will be ineffective if they do not.
- Greater resources and deployment of traffic police to detect and enforce the law. A low expectation of getting caught with breath/blood alcohol content above the legal limit has been shown to increase the risk of flaunting the law.
- Police should be granted new powers to random breath/saliva test drivers. The threat of being caught is the greatest deterrent.
- Lower alcohol level for all new drivers and commercial drivers. Teenage drivers who are alcohol-impaired are at increased risk of having a road crash if they have passengers in the vehicle, as compared with those driving alone\textsuperscript{17}.

- Many drink drivers are recidivists and SCID believes that for these drivers, in addition to penalties, more is required to keep Scotland’s road users safe. In October 2012 the ETSC published its report *Drink Drive Monitor*\textsuperscript{18}. It stated “Drink driving recidivists and high-level first-time offenders may need longer term behavioural or psychological assistance and technical monitoring, e.g. by allowing them to drive only a car equipped with an alcohol interlock for a defined time period”. The ETSC report published the progress in other EU countries in adopting the Alcohol Interlock initiative either within the commercial or rehabilitation context.

**ETSC Alcohol Interlock Barometer October 2012**

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\textsuperscript{17} Ibid.

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- At present the detection of drugged drivers is simplistic and ineffective. A Review of Drink and Drug Driving Law, commissioned by the former Labour government's Secretary of State for Transport, Lord Adonis, was published in 2010. Its author, Sir Peter North said that "it appears that there is a significant drug driving problem, which is out of all proportion to that suggested by official statistics." He concluded, "because drivers who had taken drugs were often found to be over the alcohol limit; many instances of drug-driving were not being recorded as such and were instead being treated solely as drink-driving cases, assuming police even investigated the drugs angle in the first place."

- The current field impairment test for identifying drugged drivers is totally inadequate. Hand held drug saliva testing devices are already in use Germany, Spain, Croatia, Italy, Norway and Australia. Northern Ireland's Department of the Environment is working towards creating an offence of driving with a "named substance in your body".

- Home Secretary Theresa May's commitment on behalf of the conservative Party at a TISPOL Conference (European Traffic Police Network) was that by 2012 every patrol car will carry drug testing kit and officers would be able to take a swab and scan for drug traces on the spot.

- SCID would ask the Scottish Government for an update on when hand held saliva testing devices will be available for use by Scottish police forces?

19[^19]

Submission from BRAKE the road safety charity

1. Do you agree that the drink drive limits should be reduced in Scotland?

Yes □

1A. The Scottish Government is proposing:

- A reduction in the blood limit from 80mg of alcohol in every 100 ml of blood to 50 mg of alcohol in every 100 ml of blood;
- An (equivalent) reduction in the breath limit from 35 mcg of alcohol in 100 ml of breath to 22 mcg of alcohol in every 100 ml of breath; and
- An (equivalent) reduction in the urine limit from 107 mg of alcohol in 100 ml of urine to 67 mg of alcohol in every 100 ml of urine.

Do you agree with the SG proposal to reduce the drink driving limits?

Yes

Brake is extremely supportive of the SG move to reduce drink drive limits, and recognises a reduction from 80 to 50mg as a very positive step for road safety. This is on the basis that crash risk is significantly higher for drivers with 50-80mg alcohol per 100ml blood compared to drivers with lower levels of alcohol20, and other countries that have reduced their limit to 50mg have seen a reduction in casualties21.

However, Brake would recommend a lower limit of 20mg alcohol per 100ml blood. There is a great deal of evidence that even very small amounts of alcohol impair driving. Sir Peter North’s report acknowledged that drivers with a BAC of 20mg to 50 mg/100ml have at least a three times greater risk of dying in a vehicle crash than drivers who have no alcohol in their blood22.

In the consultation the SG states at paragraph 3.06 that “by setting the limit at (50mg) where considerable impairment to driving is shown likely to take place, we can avoid criminalising drivers who may have the remnants of alcohol in their system even though it is quite some time since they had a drink or they drank very little and where there is no significant impairment to their driving.”

The findings of Sir Peter North, and a range of academic studies, contradict this statement, as a 300% increase in risk for drivers with a BAC of 20-50mg equates to a significant level of impairment. Brake also does not believe the government should legislate to protect drivers who engage in ‘morning-after drink driving’, which surveys23 and police data24 indicate is also a very significant problem. Driving with a

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21 The effectiveness of reducing illegal blood alcohol concentration (BAC) limits for driving: Evidence for lowering the limit to .05 BAC, Pacific Institute for Research and Evaluation, 2005
significant amount of alcohol in your body, at a level which is shown to significantly inflate crash risk, is dangerous no matter what time it occurs or how long after the drink was consumed, and therefore should be treated seriously in the eyes of the law. There are ways drivers can ensure they are sober and fit to drive the morning after, most simply by avoiding drinking if they have to drive early the next day.

Brake suggests that while lowering the limit to 50mg alcohol will save lives and prevent injuries, it will not achieve the stated aim of sending a clear message that people should not drink anything and drive. Instead it sends a message that people should not drink much and drive, which leads to confusion and continued debate about how much is too much, when we know that one small drink dramatically impairs driving. The best way to achieve SG’s aim of sending a clear message you should not drink and drive would be to set a limit of 20mg alcohol per 100ml blood. This is a level so low that you could not expect to have one alcoholic drink and be under the limit, so the message is clear and strong, but it does account for naturally occurring levels of alcohol in breath, so it is also practical and enforceable. It is a limit that has been successfully implemented in countries such as Sweden, where the drop from 50mg to 20mg resulted in fewer drink drive casualties25. Only with this limit will the law properly reflect scientific facts on the risks associated with driving after drinking alcohol.

2. Do you have any evidence for what would be the main consequences of the SG proposals?

All the evidence suggests that these proposals would result in fewer road casualties. This is on the basis that crash risk is significantly higher for drivers with 50-80mg alcohol per 100ml blood compared to drivers with lower levels of alcohol26, and other countries that have reduced their limit to 50mg have seen a reduction in casualties27.

Brake’s experience as a provider of support services to people bereaved and seriously injured in crashes is that a huge amount of pain, suffering and upheaval results from road casualties. Therefore these proposals would help to alleviate this.

3. Do you have any evidence for what would be the financial impact of the SG proposals?

Comments:
It is estimated that each death on roads in Great Britain costs around £1.7 million, and each serious injury £190,00028. Given the evidence that these proposals would significantly reduce casualties, we could expect to see financial savings as a result.

24 Reported breath tests and breath test failures, all drivers and riders involved by day of week and time of day, Great Britain, latest available year, Department for Transport, 2012
25 When Sweden lowered its drink-drive limit from 50mg to 20mg per 100ml of blood, drink-drive deaths fell by 10%. The Globe 2003 issue 2, Institute of Alcohol Studies, 2003
27 The effectiveness of reducing illegal blood alcohol concentration (BAC) limits for driving: Evidence for lowering the limit to .05 BAC, Pacific Institute for Research and Evaluation, 2005
28 Reported road casualties Great Britain annual reports 2011, Department for Transport, 2012
4. Do you have any comments to make on the ancillary matters related to the SG’s proposal to reduce the drink drive limits?

No comments

5. Are there any other measures that should be considered in order to tackle drink driving?

Comments:
Brake also campaigns for greater priority to be given to traffic policing, so we have more police carrying out life-saving enforcement of drink drive limits, to pose an appropriate deterrent. Brake is concerned that levels of traffic policing in Scotland have fallen significantly in the past five years by nearly 4%, while general police numbers have increased by 4.5%\textsuperscript{29}. Brake believes that increased police powers to carry out random, blanket and targeted testing would also be beneficial to achieving wider testing. International evidence shows that an increase in breath testing, and introduction of random testing, both result in fewer drink drive casualties.

It is vital that when a lower limit is introduced, this is accompanied by high-profile public information campaigns informing drivers of the new lower limit. Brake would recommend this campaign informs drivers it is not safe to drink any amount of alcohol and drive, and also aims to raise awareness about the dangers of morning-after drink driving. Brake is already active in Scotland and across the UK in promoting this message via PR activities, online communications, and programmes and services for employers, schools, colleges and youth groups. Brake would therefore be pleased to discuss further with the Scottish Government how we might work together to promote this message effectively.

\textsuperscript{29} Research briefing: levels of traffic police 2007 - 2011 in the UK, Brake, 2012
Submission from the Institute of Advanced Motoring

The Institute of Advanced Motoring (IAM) has always promoted a don’t drink and drive policy and we support the reduction in the drink drive limit in Scotland. We believe it will send the strongest possible message that drinking and driving do not mix and is now completely socially unacceptable.

This measure enjoys a high degree of public support. A recent IAM online poll (2300 respondents) showed 31% support the reduction to 50mg with a further 28% supporting a zero limit. 28% did however support the status quo.

The same survey shows support for tough penalties for drink drivers with 56% wanting much tougher or slightly tougher penalties and 31% supporting current levels.

We have no doubt that this measure will be widely supported as part of the ongoing campaign to change Scots relationship with alcohol and the effects that brings on our roads. However we do wish to flag up two areas of long term concern or unexpected consequences which may flow from the new law for discussion purposes.

Areas of concern to the IAM

Graduated penalties

The Scottish Government has been given the power to vary the alcohol limit but not the penalties for the offence. This means that the current tough penalties will be applied at a much lower level. The IAM is concerned that this may risk public support in the long term for the overall drink drive enforcement approach in Scotland. Whilst our policy is to advocate taking no drink whatsoever when driving we are aware that policing in Scotland requires the consent and support of the majority of the population and this must not be jeopardised.

By this we mean that a drip feed of ‘hard luck’ stories may, over time, reduce the level of public support. For example; those caught the morning after when they feel they have tried to control their drinking, those who may view a glass of wine with a meal as the norm and perhaps even those caught on the wrong side of the border when the limit at home in Carlisle is higher.

A drink drive conviction now brings with it almost certain loss of a job, many years of increased insurance premiums and the potential for a criminal record that stays on the system for up to 20 years (as featured in the most recent Road Safety Scotland drink driver advertising campaign).

http://dontriskit.info/drink-driving/tv-campaign/

These are strong sanctions and whilst we would never condone any drinking and driving it is an issue that deserves some open discussion and consideration. In some European countries with low limits a sliding scale of proportionate penalties are available to reflect the level of alcohol in the blood. The attached document shows a wide variety of approaches – often in countries with far less developed legal
systems! Belgium, Poland, Germany, France and the Czech Republic appear to offer graduated penalties at lower limits.

It has to be said that the majority of general public do not share this concern at the moment. We asked our web poll respondents for their view on this matter and 29% did not support more proportionate penalties with a further 21% still supporting even tougher sanctions at the lower limit. However one third of respondents did support a more proportional approach to penalties at the lower level. The IAM would ask that the Scottish Government monitors closely the impact on public opinion of the new limit with a particular focus on public support for the penalties handed out to those caught at the lower limit.

Police resources

There is no clear estimate available of the number of people likely to be caught under this new provision – the IAM would have preferred a minimum pilot period of one year using digital alcometers so that the level of drink driving between the existing and the proposed limits could have been more exactly quantified. Without this information the exact impact on Scottish police and court services is unclear.

In our view it is fear of being caught that usually drives better behaviour rather than stronger and stronger penalties. This is particularly important among repeat drink drive offenders or those who ignore limits and drive whilst clearly intoxicated. The most serious crashes are caused by those who are well over the current limit.

The majority of drink drive convictions are secured through the vigilance of trained police officers out on the roads and this must continue if drink driving is to be further reduced. It must remain a clear policy priority to reduce the number of those killed and seriously injured on our roads by drunk drivers. Our concern is that time spent catching and processing those at the lower limit who have not actually caused an incident may divert scarce roads policing resources.

Neil Greig
IAM Director of Policy and Research
23 October 2014
## Blood Alcohol Level

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<thead>
<tr>
<th>Country</th>
<th>Limit Authorised</th>
<th>Special categories of drivers / Notes</th>
<th>Fines and other penalties</th>
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<tbody>
<tr>
<td>Albania</td>
<td>0.01%</td>
<td></td>
<td>Up to 40,000 ALL and possible licence suspension.</td>
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<tr>
<td>Algeria</td>
<td>0.02%</td>
<td></td>
<td>Up to 100,000 DZD or more if injury or death is caused.</td>
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<tr>
<td>Andorra</td>
<td>0.05%</td>
<td>0.02% for bus and lorry drivers.</td>
<td>150-601 EUR. Possible licence suspension.</td>
</tr>
<tr>
<td>Argentina</td>
<td>0.05%</td>
<td>0.02% for motorcycle and moped riders. 0% for bus drivers, taxi drivers and goods vehicles drivers.</td>
<td>2,186 - 7,289 ARS.</td>
</tr>
<tr>
<td>Australia</td>
<td>0.05%</td>
<td>0% for provisional licence holders in all states. 0% for professional drivers, except in the ACT and New South Wales (0.02%).</td>
<td>Up to 3,300 AUD. Possible licence suspension and/or prison sentence.</td>
</tr>
<tr>
<td>Austria</td>
<td>0.049%</td>
<td>0.01% during probationary period, 2 years after obtaining licence. 0.01% for public transports and goods vehicles drivers.</td>
<td>300 - 5,900 EUR. Possible licence suspension.</td>
</tr>
<tr>
<td>Belarus</td>
<td>0.00%</td>
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<td>1,500,000-3,500,000 BLR. Three year licence suspension and possible prison sentence.</td>
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<tr>
<td>Belgium</td>
<td>0.05%</td>
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<td>Up to 0.08%: on-the-spot fine of 150 EUR. Over 0.08%: on-the-spot fine of 450-600 EUR. Higher penalties apply if the driver is prosecuted. Possible licence suspension.</td>
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<tr>
<td>Belize</td>
<td>0.08%</td>
<td></td>
<td>500-5,000 BZD. Possible prison sentence.</td>
</tr>
<tr>
<td>Bolivia</td>
<td>0.07%</td>
<td>0.00% for bus or coach drivers.</td>
<td>Possible licence suspension.</td>
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<tr>
<td>Bosnia-Herzegovina</td>
<td>0.03%</td>
<td>0% for bus and truck drivers and for young or novice drivers (under 21 years of age or under 3 years of driving experience).</td>
<td>50-1,000 BAM. Possible licence suspension.</td>
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<tr>
<td>Botswana</td>
<td>0.08%</td>
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<td>1,000-5,000 BWP. Possible prison sentence.</td>
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<tr>
<td>Brazil</td>
<td>0.00%</td>
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<td>957 BRL. Possible licence suspension and prison sentence.</td>
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<tr>
<td>Bulgaria</td>
<td>0.05%</td>
<td>Provinceal authorities can set a lower limit (usually 0.05%). Young drivers (18 to 21 years old) as well as newly qualified drivers are not allowed any amount of alcohol in their blood (0%).</td>
<td>500-2,000 BGN and licence suspension (6-12 months).</td>
</tr>
<tr>
<td>Canada</td>
<td>0.08%</td>
<td>Provenal authorities can set a lower limit (usually 0.05%). Young drivers (18 to 21 years old) as well as newly qualified drivers are not allowed any amount of alcohol in their blood (0%).</td>
<td>600 CAD for a first offence. Possible licence suspension and prison sentence.</td>
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<tr>
<td>Chile</td>
<td>0.03%</td>
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<td>40,000-200,000 CLP if no damage is caused. Otherwise, up to 1,200,000 CLP. Possible licence suspension and prison sentence.</td>
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<tr>
<td>China</td>
<td>0.02%</td>
<td>Fine 1,000-2,000 CNY and 6 months licence suspension. Licence withdrawn for 5 years if BAC over 0.08%.</td>
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<tr>
<td>Colombia</td>
<td>0.04%</td>
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<td>515,000 COP. Possible licence suspension and prison sentence or community service.</td>
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<tr>
<td>Costa Rica</td>
<td>0.049%</td>
<td>0.02% for professional drivers and newly qualified drivers (less than 3 years).</td>
<td>227,000 CRC. Possible vehicle confiscation and licence suspension. Prison sentence if BAC is over 0.075%.</td>
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<th>Fines and other penalties</th>
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<tr>
<td>Croatia</td>
<td>0.05%</td>
<td>0% for drivers of vehicles over 3.5 t, for professional drivers (taxis, ambulances etc.) and for young drivers (up to 24 years)</td>
<td>700-15,000 HKR. Possible prison sentence.</td>
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<tr>
<td>Cuba</td>
<td>0.05%</td>
<td>0% for professional drivers (driving a bus, coach, HGV, taxi or public service vehicle), as well as for newly qualified drivers (less than 2 years’ experience).</td>
<td>60 CUC.</td>
</tr>
<tr>
<td>Cyprus</td>
<td>0.05%</td>
<td></td>
<td>Drivers are summoned to court, where a judge will determine the fine and licence suspension period if applicable.</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>0.00%</td>
<td></td>
<td>Up to 0.03% BAC: 2,500 - 20,000 CZK Over 0.03% BAC: 25,000-50,000 CZK and possible licence suspension</td>
</tr>
<tr>
<td>Denmark</td>
<td>0.05%</td>
<td></td>
<td>Fines are based on net monthly income and calculated according to the offender’s blood alcohol level. Possible licence suspension and prison sentence.</td>
</tr>
<tr>
<td>Dominican Republic</td>
<td>0.05%</td>
<td>0% for public transport and lorry drivers.</td>
<td>1,667 DOP, possible licence suspension and prison sentence.</td>
</tr>
<tr>
<td>Ecuador</td>
<td>0.03%</td>
<td>0.01% for drivers of public transport, commercial or goods vehicles.</td>
<td>264-7,020 USD and prison sentence (5 days to 12 years).</td>
</tr>
<tr>
<td>Egypt</td>
<td>0.00%</td>
<td></td>
<td>500-1,000 EGP and licence suspension. Possible prison sentence.</td>
</tr>
<tr>
<td>El Salvador</td>
<td>0.05%</td>
<td></td>
<td>57.14 USD and possible vehicle confiscation.</td>
</tr>
</tbody>
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<tbody>
<tr>
<td>Estonia</td>
<td>0.00%</td>
<td></td>
<td>400-1,200 EUR or licence suspension. Possible prison sentence.</td>
</tr>
<tr>
<td>Finland</td>
<td>0.05%</td>
<td></td>
<td>Fines are based on net monthly income. Possible prison sentence.</td>
</tr>
<tr>
<td>France</td>
<td>0.05%</td>
<td>0.02% for bus and coach drivers.</td>
<td>135-750 EUR. Harsher penalties if BAC exceeds 0.08%. Possible licence suspension (maximum 3 years) and vehicle impoundment.</td>
</tr>
<tr>
<td>Germany</td>
<td>0.05%</td>
<td>0% for young drivers (under 21s) and newly qualified drivers (less than 2 years).</td>
<td>500-1,500 EUR and licence suspension. Harsher penalties if BAC exceeds 0.08%.</td>
</tr>
<tr>
<td>Ghana</td>
<td>0.08%</td>
<td></td>
<td>6,000-24,000 GHC and/or a prison sentence.</td>
</tr>
<tr>
<td>Greece</td>
<td>0.05%</td>
<td>0% for novice drivers (less than 2 years), motorcyclists and drivers of commercial or business vehicles.</td>
<td>78-824.50 EUR. Possible licence suspension and prison sentence.</td>
</tr>
<tr>
<td>Guernsey</td>
<td>0.06%</td>
<td></td>
<td>600 GBP and 3-month licence suspension.</td>
</tr>
<tr>
<td>Honduras</td>
<td>0.07%</td>
<td></td>
<td>900-1,000 HNL.</td>
</tr>
<tr>
<td>Hong Kong</td>
<td>0.05%</td>
<td></td>
<td>Maximum fine of 25,000 HKD. Possible licence suspension and prison sentence.</td>
</tr>
<tr>
<td>Hungary</td>
<td>0.00%</td>
<td></td>
<td>Maximum fine of 50,000 HUF and licence suspension. Possible prosecution.</td>
</tr>
<tr>
<td>Iceland</td>
<td>0.05%</td>
<td></td>
<td>70,000-160,000 ISK and licence suspension (from one month to permanent).</td>
</tr>
<tr>
<td>India</td>
<td>0.03%</td>
<td>0.08% in West Bengal</td>
<td>2,000-3,000 INR and/or a prison sentence.</td>
</tr>
</tbody>
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# Blood Alcohol Level

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</thead>
<tbody>
<tr>
<td>Iran</td>
<td>0.00%</td>
<td>Alcohol is officially banned in Iran.</td>
<td>Drinking alcohol is considered a very serious crime in Iran, which can result in a heavy fine and a possible prison sentence.</td>
</tr>
<tr>
<td>Ireland</td>
<td>0.05%</td>
<td>0.02% for newly qualified drivers (less than 2 years) and professional drivers (bus, HGVs and PSVs).</td>
<td>Fines for this offence are determined by a judge.</td>
</tr>
<tr>
<td>Israel</td>
<td>0.05%</td>
<td>0% for novice drivers (less than 3 years) and for professional drivers (bus drivers, HGV drivers, business drivers, etc.).</td>
<td>Licence suspension. Drivers are summoned to court, where a judge will determine the fine to be paid.</td>
</tr>
<tr>
<td>Italy</td>
<td>0.05%</td>
<td>0% for novice drivers (less than 3 years) and for professional drivers (bus drivers, HGV drivers, business drivers, etc.).</td>
<td>527-6,000 EUR and license suspension. Possible prison sentence.</td>
</tr>
<tr>
<td>Jamaica</td>
<td>0.08%</td>
<td>Up to 1,000,000 JPY (or prison sentence) and licence suspension.</td>
<td></td>
</tr>
<tr>
<td>Japan</td>
<td>0.03%</td>
<td>Passengers of a vehicle who permit a person to drive while under the influence of alcohol are liable to heavy fines.</td>
<td>Up to 2,000 GBP fine or six months prison and licence suspension for first-time offenders.</td>
</tr>
<tr>
<td>Jersey</td>
<td>0.08%</td>
<td>Up to 500,000 KES or prison sentence.</td>
<td></td>
</tr>
<tr>
<td>Jordan</td>
<td>0.08%</td>
<td>250-500 JOD and license suspension. Possible prison sentence.</td>
<td></td>
</tr>
<tr>
<td>Kenya</td>
<td>0.08%</td>
<td>Drunk-driving can result in criminal prosecution and permanent driving licence suspension.</td>
<td></td>
</tr>
<tr>
<td>Kuwait</td>
<td>0.00%</td>
<td>Alcohol is officially banned in Kuwait.</td>
<td>500 KWD and/or a prison sentence.</td>
</tr>
</tbody>
</table>

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# Blood Alcohol Level

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</thead>
<tbody>
<tr>
<td>Latvia</td>
<td>0.05%</td>
<td>0.02% for novice drivers (less than 2 years).</td>
<td>150-1,000 LVL and temporary licence suspension. Short prison sentences apply from 0.1% BAC.</td>
</tr>
<tr>
<td>Lebanon</td>
<td>0.00%</td>
<td>There is no official limit, but a driver with a positive test after an accident is considered to be at fault and his licence is withdrawn immediately.</td>
<td>Driving licence suspension and vehicle confiscation.</td>
</tr>
<tr>
<td>Libya</td>
<td>0.00%</td>
<td>Alcohol is officially banned in Libya.</td>
<td></td>
</tr>
<tr>
<td>Lithuania</td>
<td>0.04%</td>
<td>0.02 for newly qualified drivers (less than 2 years).</td>
<td>1,000-3,000 LTL and temporary licence suspension.</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>0.05%</td>
<td>0.02% for novice drivers (less than 2 years) and drivers of commercial vehicles and taxis.</td>
<td>100-10,000 EUR and 2-4 points. Immediate licence suspension and possible prison sentence if BAC is over 0.12%.</td>
</tr>
<tr>
<td>Macedonia</td>
<td>0.05%</td>
<td>0% for professional drivers, as well as for young (under 21) and newly qualified drivers (for the first two years after obtaining their driving permit).</td>
<td>250-400 EUR and licence suspension.</td>
</tr>
<tr>
<td>Madagascar</td>
<td>0.08%</td>
<td></td>
<td>Vehicle confiscation. Drivers are summoned to court, where a judge will determine the fine and the licence suspension period if applicable.</td>
</tr>
<tr>
<td>Malaysia</td>
<td>0.08%</td>
<td></td>
<td>Up to 2,000 MYR or 6-months’ prison sentence.</td>
</tr>
<tr>
<td>Mali</td>
<td>0.00%</td>
<td>It is a criminal offence to drive under the influence of alcohol, but no fixed limit seems to have been set.</td>
<td></td>
</tr>
<tr>
<td>Malta</td>
<td>0.08%</td>
<td></td>
<td>Minimum fine 1,200 EUR and driving licence suspension for first-time offenders. Possible prison sentence.</td>
</tr>
</tbody>
</table>
### Blood Alcohol Level

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</thead>
<tbody>
<tr>
<td>Mauritius</td>
<td>0.05%</td>
<td></td>
<td>Up to 25,000 MUR and 6 months prison for first-time offenders.</td>
</tr>
<tr>
<td>Mexico</td>
<td>0.08%</td>
<td>0.05% for drivers of goods vehicles 0% for drivers of commercial passenger vehicles</td>
<td>Penalties vary depending on each state. In Mexico City, no fine is levied, but drivers with a BAC exceeding the limit are detained for up to 36 hours. In Monterrey, fines start from 2,940 MXN.</td>
</tr>
<tr>
<td>Moldova</td>
<td>0.03%</td>
<td></td>
<td>10,000 MDL. 5-year driving licence suspension.</td>
</tr>
<tr>
<td>Monaco</td>
<td>0.08%</td>
<td>0.02% for bus and coach drivers.</td>
<td>200-9,000 EUR. Prison sentence for reoffenders.</td>
</tr>
<tr>
<td>Montenegro</td>
<td>0.03%</td>
<td>0.00% for professional drivers.</td>
<td>2,000 EUR and licence suspension.</td>
</tr>
<tr>
<td>Morocco</td>
<td>0.00%</td>
<td></td>
<td>5,000-10,000 MAD and/or 6-12 months prison. Temporary licence suspension.</td>
</tr>
<tr>
<td>Mozambique</td>
<td>0.06%</td>
<td>0.00% for bus and coach drivers and for drivers of vehicles carrying dangerous goods.</td>
<td>1,500-5,000 MZN.</td>
</tr>
<tr>
<td>Namibia</td>
<td>0.05%</td>
<td></td>
<td>The driver is arrested and the fine is determined by a judge.</td>
</tr>
<tr>
<td>Netherlands</td>
<td>0.05%</td>
<td>0.02% for new drivers (for the first 5 years after obtaining their driving permit) and moped riders up to the age of 24.</td>
<td>Minimum fine 350 EUR. Possible licence suspension and prison sentence.</td>
</tr>
<tr>
<td>New Zealand</td>
<td>0.08%</td>
<td>0.00% for drivers under 20 years.</td>
<td>4,500-20,000 NZD. Possible licence suspension and prison sentence.</td>
</tr>
<tr>
<td>Nicaragua</td>
<td>0.05%</td>
<td></td>
<td>1,500 NIO.</td>
</tr>
<tr>
<td>Norway</td>
<td>0.02%</td>
<td></td>
<td>Fines are based on net monthly income. Possible licence suspension (12 months) and prison sentence (2 weeks minimum).</td>
</tr>
</tbody>
</table>

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## Blood Alcohol Level

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</tr>
</thead>
<tbody>
<tr>
<td>Oman</td>
<td>0.00%</td>
<td>It is a criminal offence to drive under the influence of alcohol.</td>
<td>License suspension. Also fine up to 500 OMR and / or a prison sentence (12 months maximum). Please note that motor insurance becomes void if the driver is found to be under the influence of alcohol.</td>
</tr>
<tr>
<td>Pakistan</td>
<td>0.00%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paraguay</td>
<td>0.04%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peru</td>
<td>0.05%</td>
<td>0.025% for lorry and bus drivers.</td>
<td>1,825-3,700 PEN, vehicle immobilisation and licence suspension.</td>
</tr>
<tr>
<td>Poland</td>
<td>0.02%</td>
<td></td>
<td>0.02% - 0.05%: fine up to 5,000 PLN and driving licence suspension up to 3 years.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Over 0.05%: fine determined by a court, licence suspension up to 10 years and possible prison sentence up to 2 years.</td>
</tr>
<tr>
<td>Portugal</td>
<td>0.05%</td>
<td></td>
<td>250-2,500 EUR and licence suspension.</td>
</tr>
<tr>
<td>Qatar</td>
<td>0.00%</td>
<td></td>
<td>10,000-50,000 QAR and/or prison sentence (1 month - 3 years).</td>
</tr>
<tr>
<td>Romania</td>
<td>0.00%</td>
<td></td>
<td>675-1,500 RON and licence suspension.</td>
</tr>
<tr>
<td>Russia</td>
<td>0.035% (measured by BrAC)</td>
<td></td>
<td>The legal limit is 0.16 mg of alcohol per litre of breath (which equals a blood alcohol content of 0.035%). 5,000 RUB (or 15-day prison term) and licence suspension.</td>
</tr>
<tr>
<td>Saudi Arabia</td>
<td>0.00%</td>
<td>Alcohol is officially banned in Saudi Arabia.</td>
<td>300-900 SAR and/or 10 to 30 days imprisonment.</td>
</tr>
</tbody>
</table>

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<tbody>
<tr>
<td>Senegal</td>
<td>0.00%</td>
<td>It is a criminal offence to drive under the influence of alcohol, but no fixed limit seems to have been set.</td>
<td>500,000-5,000,000 XOF and a prison sentence.</td>
</tr>
<tr>
<td>Serbia</td>
<td>0.03%</td>
<td>0% for professional drivers and novice drivers (for the first year after obtaining their permit). If a medical examination shows that normal functions are impaired, a driver can be fined irrespective of the alcohol level in his/her blood.</td>
<td>5,000-120,000 RSD. Prison sentence for serious offenders.</td>
</tr>
<tr>
<td>Singapore</td>
<td>0.08%</td>
<td></td>
<td>1,000-30,000 SGD. One year driving licence suspension. Possible prison sentence for serious offenders.</td>
</tr>
<tr>
<td>Slovakia</td>
<td>0.00%</td>
<td></td>
<td>Licence suspension (1-10 years for BAC over 0.10% for first-time offenders - applicable to holders of foreign driving licences, who will be banned from driving in Slovakia). A fine will be established by a court after an administrative procedure.</td>
</tr>
<tr>
<td>Slovenia</td>
<td>0.05%</td>
<td>0% for professional drivers, as well as for young (under 21) and newly qualified drivers (for the first two years after obtaining their driving permit).</td>
<td>180-950 EUR. Possible driving licence suspension.</td>
</tr>
<tr>
<td>South Africa</td>
<td>0.05%</td>
<td>0.02% for professional drivers.</td>
<td>Drivers are summoned to court, where a judge will determine the fine to be paid.</td>
</tr>
<tr>
<td>Spain</td>
<td>0.06%</td>
<td>0.03% for drivers with less than two years’ experience and for some professional drivers.</td>
<td>500 EUR and 3-6 months’ prison OR 6-12 months’ licence suspension OR community service.</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>0.05%</td>
<td></td>
<td>3,500-7,500 LKR and possible driving licence suspension.</td>
</tr>
</tbody>
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</thead>
<tbody>
<tr>
<td>Sudan</td>
<td>0.00%</td>
<td>Alcohol is officially banned in Sudan.</td>
<td>250 SDG and possible additional penalties.</td>
</tr>
<tr>
<td>Sweden</td>
<td>0.02%</td>
<td></td>
<td>Fines are based on net monthly income and calculated according to the offender's blood alcohol level. Temporary licence suspension in all cases. For serious offenders, a prison sentence or an alternative punishment may apply.</td>
</tr>
<tr>
<td>Switzerland</td>
<td>0.05%</td>
<td>From 1st January 2014: 0.01% for the following types of drivers: - learner drivers - new drivers (for 3 years after passing the exam) - driving instructors - accompanying drivers - professional drivers</td>
<td>Minimum 600 CHF. For serious offenders, fines are based on net monthly income and calculated according to the offender's blood alcohol level.</td>
</tr>
<tr>
<td>Syria</td>
<td>0.00%</td>
<td></td>
<td>25,000 SYP and 1 to 3 months prison.</td>
</tr>
<tr>
<td>Taiwan</td>
<td>0.03%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tanzania</td>
<td>0.06%</td>
<td></td>
<td>Up to 50,000 Tzs and possible prison sentence.</td>
</tr>
<tr>
<td>Thailand</td>
<td>0.05%</td>
<td></td>
<td>Up to 10,000 THB and up to 3 months prison.</td>
</tr>
<tr>
<td>Tunisia</td>
<td>0.00%</td>
<td></td>
<td>200-5,000 THD and driving licence suspension. Possible prison sentence.</td>
</tr>
<tr>
<td>Turkey</td>
<td>0.05%</td>
<td>The limit of 0.05% only applies to drivers of private cars without caravans or trailers. For drivers of other vehicles, the limit is 0%.</td>
<td>700 - 2,000 TL fine and licence suspension.</td>
</tr>
<tr>
<td>Uganda</td>
<td>0.06%</td>
<td>0.00% for professional drivers.</td>
<td>300,000 UGX or 120 USD, and possible prison sentence.</td>
</tr>
<tr>
<td>Ukraine</td>
<td>0.02%</td>
<td></td>
<td>2,550-3,400 UHD. Possible licence suspension.</td>
</tr>
</tbody>
</table>
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<tbody>
<tr>
<td>United Arab Emirates</td>
<td>0.00%</td>
<td>Driving under the influence of alcohol is considered a criminal offence.</td>
<td>Minimum 20,000 AED and/or a prison sentence.</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>0.08%</td>
<td></td>
<td>Up to 5,000 GBP and/or 6 months imprisonment. A licence suspension applies.</td>
</tr>
<tr>
<td>United States</td>
<td>0.08%</td>
<td>0.00% for drivers under the age of 21 (in all states). 0.04% for drivers of commercial vehicles.</td>
<td>Penalties vary from state to state. On top of the fine, most states apply a licence suspension too, even for first-time offenders.</td>
</tr>
<tr>
<td>Uruguay</td>
<td>0.03%</td>
<td>0% for professional drivers.</td>
<td>8,775 UYU and driving licence suspension.</td>
</tr>
<tr>
<td>Venezuela</td>
<td>0.08%</td>
<td></td>
<td>550 VEF and vehicle confiscation. Possible licence suspension - the driver may be required to pass a road safety exam before being allowed to drive again.</td>
</tr>
<tr>
<td>Vietnam</td>
<td>0.00%</td>
<td>0.05% for motorcyclists.</td>
<td>500,000-6,000,000 VND and possible licence suspension.</td>
</tr>
<tr>
<td>Yemen</td>
<td>0.00%</td>
<td>Alcohol is officially banned in Yemen.</td>
<td>Drinking alcohol is considered a very serious crime in Yemen. It can result in a heavy fine.</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>0.08%</td>
<td></td>
<td>Not available.</td>
</tr>
</tbody>
</table>

Last updated: November 2013

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