OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 28 January 2025

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 28 January 2025

CONTENTS

HEALTH, SOCIAL CARE AND SPORT COMMITTEE
3rd Meeting 2025, Session 6

CONVENER

*Clare Haughey (Rutherglen) (SNP)

DEPUTY CONVENER

*Paul Sweeney (Glasgow) (Lab)

COMMITTEE MEMBERS

*Joe FitzPatrick (Dundee City West) (SNP)
*Sandesh Gulhane (Glasgow) (Con)
*Emma Harper (South Scotland) (SNP)
*Gillian Mackay (Central Scotland) (Green)
*Carol Mochan (South Scotland) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Elena Whitham (Carrick, Cumnock and Doon Valley) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Laura Buchan (Crown Office and Procurator Fiscal Service)
Nicki Crossan (Scottish Government)
Neil Gray (Cabinet Secretary for Health and Social Care)
Assistant Chief Constable Steve Johnson (Police Scotland)
Liam McArthur (Orkney Islands) (LD)
Andy Shanks (Crown Office and Procurator Fiscal Service)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 28 January 2025

[The Convener opened the meeting at 09:15]

Subordinate Legislation

Bread and Flour Amendment (Scotland) Regulations 2024 (SSI 2024/387)

The Convener (Clare Haughey): The first item on our agenda is consideration of a negative instrument, the purpose of which is to introduce the mandatory fortification of non-wholemeal wheat flour with folic acid. That is intended to be a public health intervention that will work alongside other public health measures to help to reduce the incidence of foetal neural tube defects in Scotland by increasing the dietary intake of folic acid, and therefore blood folate levels, in women of child-bearing age.

The amendments that will be made by the instrument specify that mandatory flour fortification will take place by requiring that non-wholemeal wheat flour be fortified with folic acid in the specified quantities. The instrument amends the Bread and Flour Regulations 1998 in Scotland by introducing the mandatory requirement for non-wholemeal wheat flour to be fortified with folic acid, amending the required quantities of fortificants that are currently added to flour, introducing an exemption from the fortification requirements for small mills, and making other technical amendments.

The Delegated Powers and Law Reform Committee considered the instrument at its meeting on 14 January 2025 and made no recommendations in relation to the instrument. No motion to annul has been lodged in relation to the instrument.

As no members wish to make comments, I propose that the committee does not make any recommendations in relation to the instrument. Do members agree?

Members *indicated agreement.*

Assisted Dying for Terminally Ill Adults (Scotland) Bill: Stage 1

09:17

The Convener: The second item on our agenda is evidence from two panels of witnesses as part of our scrutiny of the Assisted Dying for Terminally Ill Adults (Scotland) Bill at stage 1.

By virtue of rule 12.2.3(a) of the standing orders, Liam McArthur MSP is attending the meeting today as the member in charge of the bill.

We begin today's scrutiny of the bill by taking evidence from representatives of the Crown Office and Procurator Fiscal Service and Police Scotland on law enforcement considerations in relation to the bill. I welcome to the committee Laura Buchan, procurator fiscal, policy and engagement, and Andy Shanks, head of the Scottish fatalities investigation unit, both from the Crown Office and Procurator Fiscal Service; and Assistant Chief Constable Steve Johnson from Police Scotland.

We will move straight to questions.

Emma Harper (South Scotland) (SNP): Good morning. I am interested in exploring issues related to the current law. The policy memorandum mentions that the member in charge believes that

"the current legal position is unacceptably unclear as there is currently no specific legislation in Scotland which makes assisted dying a criminal offence, yet it is also possible to be prosecuted for offences such as murder or culpable homicide for assisting the death of another person."

I am interested in your assessment of the extent to which the current criminal law is clear, and the extent to which the case of Ross v Lord Advocate 2016 made the position clearer.

Laura Buchan (Crown Office and Procurator Fiscal Service): It is recognised that this is a particularly difficult and emotive area of the law that raises important issues. It is therefore quite proper that any proposed change to the law should be a matter for the Scottish Parliament, whereas it is the job of prosecutors in Scotland to apply the laws that are in place. However, if it assists, I will talk through the current process in relation to assisted dying in Scotland.

As the committee will be aware—this is in the documentation that the committee has before it—there are historical differences in how the law and criminal justice systems have developed in England and Wales that make their systems quite distinct from ours.

Suicide is not a crime that is known to Scotland, and there is not a distinct crime in Scotland of assisted suicide. In contrast, in England and

Wales, there is a statutory offence of assisted suicide, but the Suicide Act 1961 does not apply to Scotland.

In Scotland, if someone assists another person to take their own life, the case would be reported to the procurator fiscal as a deliberate killing of another person and would be dealt with under the law relating to homicide. Under the law of homicide, we would have to consider whether there was sufficient evidence to determine that an offence had been committed, that the individual was the perpetrator of that offence and that that individual had the requisite intention to commit the offence.

In terms of the case that Ms Harper referenced, we would have to show that there was a direct causal link between the action of the perpetrator and the deceased's death—it would have to be a significant contributory factor to the death. There is a considerable amount of case law around causation and contributing factors that is required to be carefully considered in the circumstances. In every case that is reported to us, we have to consider all the facts and circumstances that are before us, and the evidence.

Once we have reached that stage in the process, we would have to consider whether any prosecution would be in the public interest. The criteria for deciding whether a case should be prosecuted is set out in the prosecution code, which is a document that is available on our website.

The taking of another life is one of the most serious offences in Scotland, so there is a high level of public interest in prosecuting aspects of homicide where there is sufficient available evidence. Ultimately, if we decided to prosecute, it would be for the jury to decide whether the standard of proof had been reached and to determine whether somebody was guilty of culpable homicide. It would be for the court to ultimately determine the appropriate sentence, taking into account any mitigatory factors that existed.

That is the current law in Scotland relating to how we would consider cases of assisted suicide that were reported to us.

Emma Harper: Does the bill, as drafted, provide a pathway for somebody to end their life without others being prosecuted? Does it interact with the current law in a way that facilitates the prosecution of offences around suicide and assisted dying that are not covered by the requirements of the bill? The bill is about somebody choosing to be assisted to end their life if they are terminally ill.

Andy Shanks (Crown Office and Procurator Fiscal Service): Good morning. I am happy to answer that. There is a provision in the bill that sets out that there would be no criminal liability where someone has lawfully provided assistance to someone else to end their life. The protection provided by that provision would therefore only apply if such assistance was lawful.

The first thing that we would consider would be whether the process had been lawfully adhered to. If the assessment was that it had not been lawfully adhered to, the existing criminal law would apply to anyone involved in any potential offence or offences relating to that.

Emma Harper: Okay. I am thinking about healthcare practitioners. I am a registered nurse—I need to remember to say that. Is there provision for healthcare practitioners who would be participating in the process of helping somebody to end their life?

Andy Shanks: Yes. It is important that the provisions are as clear as possible, not only for the benefit of those investigating any death, but for the benefit of those who seek to follow the procedures that are put in place. We would welcome the greatest degree of clarity and certainty possible.

Brian Whittle (South Scotland) (Con): Good morning. Coercion is one of the main issues that has been raised by almost every single panel of witnesses that we have spoken to. Do you consider that the bill, as it is written, is sufficiently clear to enable prosecutions? Could you give us an idea of what kind of evidence you would want to be considered in that context?

Mr Shanks is probably in a good place to start answering that question, so I will ask him first—or Ms Buchan.

Andy Shanks: It is probably more a question for Ms Buchan in the first instance.

Laura Buchan: One of our observations about the bill relates to the provision in section 6(2)(c), which is about medical practitioners making an assessment of whether the person has been coerced or pressured. As Andy Shanks said, it would help medical practitioners to have clarity around and understanding of the process and what they would be required to take into account to determine whether somebody had been coerced or pressured so that they could satisfy themselves of that. It is also not clear in the bill how, if the medical practitioner has any concerns about coercion, those concerns might be raised with the relevant authorities. There might also be scope for disagreement among practitioners about whether there is coercion.

One of our observations is therefore about clarity around what we mean by coercion and pressure, how a medical practitioner would determine whether there was coercion and pressure, and how they would intimate that there

had been coercion and pressure in the process so that that could be considered.

There is no offence of coercion in Scots law. It is more ordinarily discussed in the context of defences. Much of our consideration would depend on whether the coercion came to light during the process or was raised by another person after the process had been completed. That would determine how the police and the Crown would require to consider that in terms of offences.

Brian Whittle: If coercion is not currently an offence, I presume that it would become an offence within the context of the bill. We would be asking members of the medical profession, who are not members of the legal profession, to make a judgment on something that might break the law. Is that a fair comment?

Assistant Chief Constable Steve Johnson (Police Scotland): We have raised the same issues about coercion and pressure during the process, and we would say exactly the same thing. If a case were referred to the police for an investigation, what would be the scope and scale of our investigation, and how would we report it to the Crown? The bill seems to create an offence at that stage but not after the event, and our primary concern would be about where we would sit if, after the event, a distant relative or a third party were to come in and say that they believed that there was coercion.

There need to be clear guidelines for medical practitioners who are making the statements. The co-ordinating registered medical practitioner and the independent registered medical practitioner are asked, at point 2 in the statement forms, to declare that, to the best of their knowledge, there has been no coercion, but how do they know that that is the case? What was the nature of their inquiries? What questions did they ask the individual who is in front of them about whether there has been a broad conversation between interested parties in their family, for example? We are therefore keen for there to be clear guidelines for medical practitioners about how they come to the conclusion that there has been no coercion or pressure.

Brian Whittle: Correct me if I am wrong, but you said that coercion happens prior to the person having an assisted death. If that person goes through with the process and it is found later on that there was coercion, surely that is the offence. If coercion is caught prior to the death, the person would be prevented from dying in the first place. Surely the offence is after the death.

Assistant Chief Constable Johnson: Is it in the declarations?

Laura Buchan: No—after death, that could be considered under the law of homicide. It would fall outwith the realms of the bill. My understanding of the bill is that there is an offence of coercion during the process, so somebody could be reported for coercion if it was raised by one of the medical practitioners at any stage of the process or declarations. However, if it was raised after the person had died, that would potentially take it outwith the process and open the opportunity for a homicide investigation.

09:30

Andy Shanks: Yes, I think that that is right. The stated offence relates to either the first or the second declaration, so it could come to light before or after death, and, as Laura Buchan has said, it could potentially be considered in a slightly different way.

Brian Whittle: In that case, would there also be the potential for coercion to prevent somebody from having an assisted death? Would that be an offence?

Laura Buchan: My understanding is that that would not be a coercion offence under the bill. I think that there is such an offence in some jurisdictions—potentially in Australia—but not under the bill, as drafted.

Andy Shanks: I think that that is right. For it to be an offence under the bill, the person would have to be coerced into making either a first or a second declaration in the process.

Assistant Chief Constable Johnson: I think that we need guidance on that. I think that, if somebody were to be coerced into the positive act of making a declaration either at the first stage or in the second declaration, that in itself would be an offence under the bill. My understanding is that, if that person went on to complete the process, we would undertake a homicide investigation and everything that goes along with that, which is why clarity is really important.

Brian Whittle: I think that there is a difference between the Terminally Ill Adults (End of Life) Bill, which is going through the United Kingdom Parliament, and this bill, with the UK Parliament bill containing a wider range of offences than the Scottish bill. Should we be closer to what the UK Parliament is looking at, or would that cause us more issues?

Assistant Chief Constable Johnson: Having had a look at the England and Wales bill, I see that it contains a three-stage process. It is very similar to the proposal in this bill, but the third stage of the process, which is in the High Court, is a distinctly separate aspect.

Clause 26 of the UK bill would introduce offences that are very similar to what we have in this bill around coercion or pressure, but it includes the element of dishonesty when somebody behaves with such a mindset in seeking to achieve their ends. The clause 27 offences are very much around the role of registered medical practitioners if they create a false document or statement to enable someone to end their life. Those are additional offences.

For us, anything beyond the act through which a person's life was ended would be culpable homicide at the very least—and possibly murder—and would be investigated under Crown direction. That is my understanding. Irrespective of whether we need specific legislation in Scotland through this bill, we can rely on the culpable homicide and murder aspects of the investigation.

Brian Whittle: I have a short question on definitions in the bill, relating to what qualifies as a terminal illness and the act of self-administration, for example. What we mean by self-administration is another area that has been quite thoroughly looked at during our evidence taking. Under the bill, we assume that it would mean ingestion of some concoction, but we have also looked at what that would mean for the human rights of somebody who cannot swallow and who might have to go down another route. In relation to that, if something went wrong, what would be the legal requirement on the medical professional who was there at the time? Would they have to step in and save the person's life? That is a grey area that worries me, Mr Johnson.

Assistant Chief Constable Johnson: That is something else that we agree on. Section 15(5) says that the medical practitioner who provides the administration of the substance has to be present. However, the very next subsection says that that person can leave the room. There is ambiguity there: when somebody is expected to ingest or self-administer the substance, the medical practitioner must be present under section 15(5) but can leave the room under section 15(6). For me, that needs to be clearer.

Section 15(5) says that someone could provide the substance and remain present until the person had ended their life. However, on my reading—which I think is a shared one—of section 15(6), having provided the substance, that person may then leave. Between subsections (5) and (6) there is ambiguity on whether there needs to be external observation of what takes place in the room when the person goes on to self-administer, or what happens if other people present in the room intervene. From the perspectives of policing and investigation, we need clarification of those aspects. It would be terrible to think that the person might have changed their mind but that someone else in the room had administered the substance on their behalf. At that point, this legislation would feel very frail.

Laura Buchan: Such situations are very personal, but we envisage people usually taking comfort in being with their loved ones when they die. There needs to be clarity on whether the medical person is to be there, or what happens when they are not but family members are in the room when the self-administration takes place. That can—or might—have a bearing in terms of criminal investigation. That goes back to our point about achieving clarity for COPFS and the police on what the legislation requires of the process.

You also touched on the definition of terminal illness. We are not medical professionals. As regards medical practitioners having to make a determination as to whether any such definition has been satisfied—which we know is not easy—more clarity on its breadth would be helpful for us in our investigations.

Andy Shanks: I agree with that. From the death investigation perspective, we really need clarity. I referred to considering each step in the process to ensure that it had been lawfully complied with. That exercise would certainly be aided by having clarity on the definitions and the various steps.

I reiterate the point about the provision of assistance. It is clear that the medical practitioner has to be there, although not necessarily in the same room. However, the bill is silent on who else can be there. That could create a scenario where the medical practitioner is not in the room at the point when the substance is administered, but another party might be. That could raise concerns about whether we had a full understanding of the circumstances in which the substance was administered and by whom.

Sandesh Gulhane (Glasgow) (Con): I declare an interest as a practising national health service general practitioner and as chair of the medical advisory group on the bill.

I have a couple of questions, the first of which is on coercion. You mentioned what might happen after the event. How would you unpick the following scenario? Say that someone who has decided that they want to go through with an assisted death has a supportive family member, as we hope would be the case, but after the event, another family member—perhaps a distant cousin, for example—says, "I'm against the idea of assisted dying, and you've clearly coerced because you have been so supportive." Would you be open to multiple complaints coming through?

Assistant Chief Constable Johnson: That is a good articulation of a worry that I have about exactly that situation. Families might be extended or distant. For us, the legislation is clear on its

intentions as regards the person who is making a decision about their own time of death. If another person were to come along later, in the way that you have described, we would consult the Crown. However, if we then had to begin a murder or culpable homicide investigation, that would be a full police investigation into a family group that has already been traumatised by the passing of a loved one. There would also be investigation of the circumstances that had led to someone's believing that there had been coercion.

We seek clarity on how two medical practitioners could sign statements to say, "We believe that no coercion or pressure has knowingly been put on that person", and which would stand scrutiny by the Crown and ourselves so that the case would not be referred for police investigation. The practitioners would have to have the full protection of the law saying that they have followed the rules on assisted dying, with clear guidance for medical practitioners on how to determine that there has been no coercion or pressure.

That point is, if you like, a clear-cut ending to the process. We are concerned that without that clarity, people might end up in really challenging situations with a full police investigation into circumstances that the bill could have addressed before being enacted.

Sandesh Gulhane: I have another question. Such a thing occurring would be extremely rare, but where would you stand on somebody falsifying their having a terminal illness and ending up having an assisted death?

Laura Buchan: That is very difficult. I am not sure that we can or should get into discussion of hypothetical situations of how the bill would be applied. It is difficult to imagine a situation in which an individual would be able to fake a terminal illness. However, in relation to prosecution of a person who was assisting, we would need to go through the process of investigation to determine whether that sat within the powers of the bill. Notwithstanding whether there had been falsehood, it would be subject to an investigation.

Andy Shanks: I go back to what I said about the initial assessment of whether the process has been lawfully complied with. It might not have been lawfully complied with, for whatever reason, but that does not necessarily mean that there is underlying criminal conduct. It could mean simply that the safeguards or the protection around criminal liability no longer exist, so we would have to consider the facts and circumstances and any potential offences.

Assistant Chief Constable Johnson: The two registered medical practitioners would declare, in the wording of the declarations in the bill:

> "I am of the opinion that they are terminally ill".

We suggest that the bill in England and Wales will create an offence if a person were to falsify a document. I am a police officer, not a doctor, but if a registered medical practitioner, with their knowledge of medicine, said that they believe that that person is terminally ill, that would have to stand on its own. It would not just be for the person to declare that they have a medical illness: two practitioners must certify that view.

If that process were to be conducted, I think that we would be in similar territory to, as I say, England and Wales, where the bill says that if a doctor falsifies statements, there will have been a clear offence—but there is not such an offence in this bill. We would be straight into culpable homicide and probably murder, especially if the person in question was providing the substance. We would have to investigate motivation and so on.

Elena Whitham (Carrick, Cumnock and Doon Valley) (SNP): Good morning. I will continue on the issue of death investigations should the bill pass into law, and the interaction with article 2 of the European convention on human rights. Have witnesses had a chance to consider what level of investigation might be appropriate in assisted deaths? For example, do you foresee a requirement for all assisted deaths to be reported to the Crown Office and for the people involved to be interviewed in every case?

Andy Shanks: I am happy to answer that one. As you will be aware, the Lord Advocate has responsibility in Scotland for the systems of prosecution and the investigation of deaths, and she makes decisions in relation to those functions independent of any other person. I am currently the head of the Scottish fatalities investigation unit, and have operational day-to-day responsibility for the investigation of all sudden, suspicious and unexplained deaths on behalf of the Lord Advocate and in the public interest. Deaths that are reported to us are investigated rigorously, respectfully and compassionately.

A death investigation in Scotland has a number of purposes. Most obviously, an investigation is carried out to identify whether there is any criminality associated with the death, but beyond that there are wider purposes for a death investigation. First and foremost, it is about ensuring that every death in Scotland has a medically certified cause of death. It is also about ensuring that bereaved relatives have an understanding of the circumstances in which their loved ones died and answering any concerns that they might have. It is also about identifying any lessons that can be learned for the future in order to prevent similar deaths from occurring.

The nature and extent of an investigation will depend on the facts and circumstances in each reported case. We take a rigorous approach to death investigation, but it is proportionate to the circumstances. We receive between 13,000 and 15,000 reported deaths every year from Police Scotland or medical practitioners.

09:45

As you might be aware, medical practitioners are currently issued with guidance on the deaths that require to be reported to the procurator fiscal. That can include deaths where the medical practitioner is unable to certify, for whatever reason, or where they have particular concerns around the circumstances of death. There are also mandatory categories of death that must be reported. One of those categories, broadly speaking, relates to unnatural death.

Ultimately, it is a matter for the Lord Advocate whether that guidance would be changed: I cannot commit to a position on her behalf today. However, were the provisions to come into force, it is likely that deaths using the assisted dying process would require to be reported to the procurator fiscal as a mandatory category of reportable death.

Elena Whitham: Further to that, would it be worth considering whether we should, with regard to assisted dying cases, establish an independent review panel with investigatory powers?

Andy Shanks: Deaths are already investigated independently by the COPFS on behalf of the Lord Advocate, which would bring that degree of independent scrutiny to the circumstances of the death. That is not only done in relation to the potential for criminality but, beyond that, in terms of wider death investigation purposes, it is done to see whether there are systemic issues or issues of public concern that require further investigation—or, indeed, whether it is in the public interest to hold a fatal accident inquiry. Therefore, I think that independent scrutiny would already exist.

Elena Whitham: Okay. At this point, in that case, you do not foresee a requirement to set up another body that would deal only with assisted deaths, should the provisions come into force. Do we, as things are currently set up, already have provision to deal with assisted deaths, with the Lord Advocate having that overarching role under current law?

Andy Shanks: That would depend on purposes. If you are talking about data collection and data analysis, they should probably be carried out by a separate body. The functions of the Lord Advocate are clear in relation to the purposes that I have described. I do not think that anything in the provisions of the bill would impact on the Lord Advocate's overall responsibility for investigation of deaths.

Elena Whitham: Over the years, there have been families and individuals who have perhaps felt that their article 2 ECHR rights have not been realised under the current set-up for death investigations in Scotland. Is there sufficient public scrutiny and involvement of the next of kin in death investigations?

Andy Shanks: We involve bereaved relatives in death investigations from the earliest possible stage. As I said, between 13,000 and 15,000 deaths are reported to us every year. For the vast majority of those deaths, we complete our involvement relatively quickly and we involve bereaved relatives. At the moment, for deaths that are reported to us that do not require investigation, we are concluding our involvement within six weeks in 98 per cent of cases. For deaths that require a degree of investigation, we are concluding our involvement within 12 weeks in over 70 per cent of cases. That involves explaining the outcome to the bereaved relatives and addressing any particular concerns that they have.

Elena Whitham: Thank you.

David Torrance (Kirkcaldy) (SNP): Good morning. Do you have views on whether the monitoring and review processes in the bill are sufficient, particularly from human rights compliance and law enforcement perspectives? Do you have any suggestions on how the bill could be improved in that area?

Andy Shanks: I do not think that I have much to add to my previous answer, to be honest. It is for Parliament to decide whether to require that enhanced monitoring provisions be in force. The Lord Advocate's responsibility will exist regardless. It will be in the public interest to ensure that there is a degree of independent investigation and scrutiny of the circumstances of every assisted death.

David Torrance: The bill stipulates that an individual's terminal illness, as opposed to ingestion of a lethal substance associated with assisted dying, would be recorded as a cause of death on the death certificate. Do you have concerns about how that might impact on a death investigation process?

Andy Shanks: I do not think that that would impact on a death investigation process and it would not affect how we approach an investigation. However, in normal circumstances, the medical practitioner who is certifying a medically certified cause of death would do that to the best of their knowledge and belief, so the provisions would signify a departure from that. That is probably most relevant in respect of national data collection. The committee might want

to query that with the death certification review service, which performs that function.

Gillian Mackay (Central Scotland) (Green): Thanks, convener, and good morning, witnesses.

Do you foresee a risk of confusion between the various eligibility criteria for assisted dying in different parts of the UK? Is there an associated risk that that would make law enforcement more complex? If so, what do you believe should be done to address that? Unbelievably, I will go to Steve Johnson first. [*Laughter.*]

Assistant Chief Constable Johnson: I have probably already articulated that there are some differences in application of the law. From a selfish perspective, if that is the law of the land and that is how it operates in Scotland, I have no concerns other than those that we have raised about the nature of the eligibility criteria.

If I did have concerns, they would be more general. In England and Wales, there is a proposal for a three-step process that would involve the High Court. The terminology on eligibility at the start of the bill sets out that ordinarily someone would have to have been living in Scotland for a year before they would be able to access the provisions in bill, but I am not sure what "ordinarily" means. Would that mean that someone could opt not to go through the three-step process in England and Wales, which would involve the High Court, but could choose to come to Scotland, instead? How long would someone have to have been in Scotland, and what does "ordinarily" mean?

I would not want Scotland to become a destination of choice for people to come here to use the powers that we would have to end their lives, rather than using the related powers in their country. That could increase the burden on us in terms of investigations, and might involve more people outside the jurisdiction. A lack of clarity on that could make the process more challenging and we might have to conduct investigations that would span a person who used the legislation in Scotland when most of their relatives would be in England and Wales.

The other aspect relates to the age requirement. The United Nations Convention on the Rights of the Child is clear and unambiguous that a person is a child until they are 18. However, the bill sets out that a person is considered to be an adult from the age of 16. So—which is it? Which definition would you want me, as a law enforcement officer, to use? Clearly, someone who is 17 is considered to be a child under the convention and would have rights to parental support, but according to the bill a 16-year-old could determine that they want to move forward with a provision that would allow them to seek to end their life.

I seek clarity as to whether the bill considers a person to be an adult at 16. If so, that is not consistent with many other pieces of legislation in Scotland. If the Parliament deems that it wants assisted dying provisions to be available to children, as they are defined by the UNCRC, there would need to be very clear guidance and guidelines about the roles of parents and of children. That would create disparity between ourselves and other jurisdictions and might make Scotland an attractive place for people to come to so that they could access the proposed legislation.

Gillian Mackay: Would anyone else like to come in on that, before we move on?

Laura Buchan: We have discussed and made similar observations about age and the tension between the bill and the UNCRC's definition of a child, which was incorporated into Scots law in July 2024. There is also some concern about the term "ordinarily resident" and what that would mean. We also need some clarity on the position in England and Wales, as against the position in Scotland.

Gillian Mackay: That is useful.

How do you believe Scotland's legislation could best ensure that there is clarity, and minimise complications for individuals and families who are navigating the different legal frameworks on assisted dying across the UK, to ensure that they do not fall foul of any rules, which Steve Johnson has just talked about? Laura, how can we make it easy for families to navigate, so that they do not end up under investigation by either the police or the COPFS?

Laura Buchan: I will follow on from Andy Shanks's point and note that death investigations in Scotland are undertaken rigorously and compassionately. An investigation is not, I suppose, about trying to trip people up in terms of their not having followed the process, if they have used their best endeavours to follow it.

That relates to our point that it is, ultimately, for parliamentarians to determine what is in the bill. However, for the purposes of investigation and consideration, the more clarity people who want to follow the process have, the better, in order to ensure that they are following the right steps and the right process. People—family members and friends, and medical practitioners—should be absolutely clear about the process.

For us, that would mean that, when that death is reported, a limited amount of death investigation needs to be carried out in order to ensure, in a compassionate way, that families can deal with their loss and that investigations can be closed. The risk of not having that clarity is that it potentially opens more deaths up to investigation.

Andy Shanks: I agree entirely with that. I repeat the point that I made about the proportionate approach that we take to death investigations.

It is difficult to get into hypothetical scenarios, but it is possible to imagine a scenario in which our involvement in an investigation of that type would be relatively brief—where it was clear, for example, that the process steps had been followed throughout and no concerns were expressed by any party involved.

Assistant Chief Constable Johnson: On the point that Laura Buchan made, I note that the guidance will be exceedingly useful not only for the people who would be directly involved, but more widely.

That relates to Sandesh Gulhane's question about the wider family, and the possibly displaced family. Even if they do not access the provisions through people being involved in the process, they could see that it is open to the public and that there is absolute clarity around the steps, the terminology, the language that is used and how that is interpreted by the law system. We would find that useful.

Brian Whittle: I tried before to cover this. It is a question that is buzzing around in my head about whether there is enough protection in the bill for healthcare professionals. I think that my question is this. If something goes wrong during the process of taking a substance, what then is the legal responsibility of the healthcare professional? Are they liable for prosecution if they step in and save the person, or are they under pressure the other way, if they do not step in and save the person? Does the bill clarify that enough to protect healthcare professionals?

Laura Buchan: Again, I say that hypothetical scenarios are difficult. However, our observation is that there should be some clarity around that. I do not see from the proposals in the bill that there would be an offence if, for some reason, something went wrong and the medical practitioner was required to step in. I cannot think of, or consider, what such an offence might be. However, again, it would be far better for medical practitioners to have clarity.

We have dealt with cases in which there is a "Do not resuscitate" notice or plan in place, so that it is clear for those involved. It would be helpful to have some clarity in the bill around that process and what happens in terms of self-administration.

Andy Shanks: I completely agree with that.

I go back to the point that I made earlier. It is possible to have a process that is not considered to be lawful, for whatever reason, but which does not automatically mean that a criminal offence has been committed. The circumstances would have to be considered carefully, but it is difficult to get into those hypothetical scenarios at the moment.

Assistant Chief Constable Johnson: We, too, would want clear guidelines.

I am not sure how the process would work in terms of the substance that people administer, but things work in different ways and might present differently. We would not want people in the room reacting to something that they are seeing, but which is predictable. I am perhaps not explaining myself very well. If, in the manner of dying, people present in a certain way that people might think is, for example, distress, but is perfectly normal and is how the substance works, we need to make sure—I suggest that we need guidance—that people who are in that room, if there is anybody else in the room with the person, are aware of that and are not just reacting to what they see in front of them.

I do not know whether I have explained that very well—

Brian Whittle: No, I completely understand.

Assistant Chief Constable Johnson: You would seek to limit people's desire to intervene, rather than leaving it to happenchance.

10:00

Sandesh Gulhane: I want to look at the interaction across the UK a bit more. There is no guarantee that either bill will pass, but if the Scottish bill passes but not the English one, do you foresee a potential problem, with families who are supporting ordinarily resident Scots from England getting into trouble due to the law not changing in England?

Laura Buchan: It is very difficult to say. From our perspective, as long as the family and the medical practitioners followed the terms of the bill, the matter would fall within its scope, which would, again, limit the investigation. That situation might mean that people move to Scotland for a period to allow themselves the opportunity to use the provisions in the bill. That would sit within the terms of the bill as it is drafted. I refer back to Steve Johnson's point around clarity.

Assistant Chief Constable Johnson: It comes back to one of the differences in terminology. In England and Wales, the bill provides that a "terminal illness" will last for a period of "6 months", so, if you are south of the border, timelines are quite tight. What happens if people cannot access the service? That is why I asked the question about "ordinarily resident". The bill talks about a year, but would people consider less time than that? We need that clarity.

However, I do not foresee any problems. Given the caveats in our feedback on the bill, if the bill, the guidance and the process are clear, and as long as the criteria are met, I do not anticipate the vast majority of cases even being reported to the police by the Crown, the hospitals or the GPs who administer the service. It would be between them and the Crown, and involvement of police and law enforcement would be minimal.

Sandesh Gulhane: This might be very stupid, but I assume that, if you had a complaint and you were an English resident with a Scottish family member, you would make the complaint in Scotland rather than in England.

Assistant Chief Constable Johnson: Clearly, we would handle a complaint about the process in Scotland for someone who is resident in Scotland, where we have jurisdiction. If somebody complained about something that happened in England and Wales, we would facilitate that and find out the appropriate jurisdiction in the forces in England and Wales to make that complaint to, because it would be for them.

Sandesh Gulhane: Okay. Thank you very much.

The Convener: I thank the panel members for their attendance today. The committee has found your evidence to be very helpful in our scrutiny of the bill at stage 1. I briefly suspend the meeting to change over witnesses.

10:02

Meeting suspended.

10:14

On resuming—

The Convener: We continue our scrutiny of the Assisted Dying for Terminally Ill Adults (Scotland) Bill by taking evidence from the Cabinet Secretary for Health and Social Care and supporting officials. I welcome to the committee Neil Gray, the cabinet secretary; Nicki Crossan, assisted dying shadow bill team leader; Ailsa Garland, principal legal officer; Neil Ritchie, palliative care unit head; and Joanna Swanson, healthcare quality and improvement divisional head, all from the Scottish Government.

Before we move to questions, I believe that the cabinet secretary would like to make a brief opening statement.

The Cabinet Secretary for Health and Social Care (Neil Gray): Good morning, colleagues, and thank you very much for your invitation to give evidence to the committee on what is, as I am sure that you have found throughout your evidence gathering, a very sensitive and emotive topic.

As I outlined in my memorandum to the committee in September, the Government is taking a neutral position on Liam McArthur's bill at this stage, and it is for the Parliament to decide whether it supports the general principles behind the bill. Given that, I am not in a position to comment on assisted dying in principle or on the individual provisions in the bill, beyond what I have already outlined in the memorandum.

It is important that I, as lead minister on the bill, and the Government, remain neutral while the Parliament carries out its scrutiny. However, my officials and I have been closely following the evidence that the committee has gathered over the past few months. The work that you have been doing and the evidence of stakeholders will play an important role in supporting our decision making on any amendments that we might wish to lodge, should it pass stage 1. I also look forward to reading the committee's stage 1 report when it is published.

This is a hugely complex, emotive and contentious topic, and it remains my hope that, regardless of our personal views, we as MSPs will be able to work together across parties to ensure that the debate continues to be handled with the sensitivity that it requires and deserves. I am grateful to the committee for the respectful way in which it has handled its scrutiny thus far, and I thank you again for inviting me to give evidence on this important issue.

The Convener: Thank you very much, cabinet secretary. We will move straight to questions.

Gillian Mackay: Cabinet secretary, could you expand on the Scottish Government's concerns on legislative competence? For clarity, do you regard the bill as being outwith the legislative competence of the Scottish Parliament, or is the Scottish Government concerned that it might not be possible to implement aspects of the bill within the current restrictions on legislative competence?

Neil Gray: I cannot say much more than I have already said in my memorandum to the committee. However, to summarise the Government's views, we believe that the bill in its current form is outside the legislative competence of the Scottish Parliament. In particular, we believe that section 15(8), which gives power to the Scottish ministers to specify in regulations a drug or other substance as an "approved substance" to be provided to terminally ill adults to end their own life, appears to relate to the reserved matter of medicines, medical supplies and poisons, as set out in section J4 of schedule 5 to the Scotland Act 1998.

Given that the bill represents a novel and fundamental shift in the role of medical

practitioners and the regulatory framework in which they operate—a shift from protecting or enhancing patients' lives to assisting in the termination of life—we also have concerns that some of the other provisions in the bill may relate to the reserved matter of the regulation of health professionals, as set out in section G2 of schedule 5 to the Scotland Act 1998. That is a confirmation of the position that I set out in the memorandum.

Gillian Mackay: The member in charge of the bill has identified some routes that could be used to deal with some of the competence issues, which include orders under the Scotland Act 1998. If the bill passes stage 1, will the Scottish Government commit to discussing those matters with the United Kingdom Government?

Neil Gray: I note those comments on Mr McArthur's endeavours. It is for the Parliament to decide on the bill at stage 1. We would then need to consider our position on the basis of what we have set out prior to the stage 1 debate, including what I set out in the memorandum. We would explore any opportunities should the bill pass stage 1.

Elena Whitham: I am interested in questions relating to the European convention on human rights. I am thinking about article 2, which is the right to life, article 8, which is the right to respect for private life, and article 14, which is the prohibition of discrimination. I will frame a few questions about those.

What advice, if any, has the Scottish Government sought on the bill's compliance with the ECHR and the likelihood of any legal challenge arising should the bill be passed?

Neil Gray: I note that those questions were considered by the previous panel, particularly in relation to prosecution policy and investigations. We have considered Mr McArthur's equality impact assessment. Depending on the consideration that the committee gives to those questions, further work may be required post stage 1. However, at this stage, I will rest there.

Elena Whitham: I have a further question in the context of human rights. What is the Scottish Government's view on whether the bill contains sufficient protections in relation to vulnerable groups? If there are any concerns in that regard, what could be done to address them?

Neil Gray: Again, that is for Mr McArthur to consider. We have not taken a policy position on that issue. The Government does not have a policy position on the elements in the bill, so we would need to consider and determine the issues on the basis of the evidence that is gathered by the committee, should the bill pass stage 1.

Elena Whitham: I will ask my next question, but I am not sure that you will be able to answer it. Similarly, to what extent do you believe that the process in the bill is compliant with the prohibition on discrimination contained in the ECHR? If it is not compliant, how would you like to see that addressed?

Neil Gray: In the course of this session, I will try to be as helpful as possible. I hope that you will note that, in response to Ms Mackay's questions, I tried to give as expansive an answer as I could. I cannot say anything beyond what I have already set out and what is already in the memorandum that I sent to the committee.

Elena Whitham: Thank you.

David Torrance: Has the Scottish Government undertaken its own estimate of costs arising from staff time? Can you detail how they differ from those that are set out in the financial memorandum?

Neil Gray: In the memorandum that I sent to the committee, we queried the financial memorandum. I note that Mr McArthur has done some further work on the back of that. However, we have concerns that the costs that have been set out in the financial memorandum do not go as far as what we believe could end up being the cost. It may well be that the bill would require a financial memorandum to be associated with it.

David Torrance: What is the view of the Scottish Government on the adequacy of the training expectations that are set out in the bill and the financial memorandum?

Neil Gray: In the Government memorandum, I set out the elements around the potential costs. On the particular issue that Mr Torrance raises about training costs, if we were to assume that half of all doctors would undergo training, and that the training time would be around seven hours—as is suggested in Mr McArthur's financial memorandum—there would be a total cost of just over £6 million for training time, which has not been factored in. Again, that is for the Parliament and the committee to consider. We have noted that as part of our memorandum to the committee for you to consider.

David Torrance: I have no further questions.

The Convener: Before I ask my question, I put it on the record that I hold a bank nurse contract with NHS Greater Glasgow and Clyde.

Can you clarify, cabinet secretary, whether you are talking about training costs for medical staff or for all healthcare staff? We anticipate that there would be pharmacists involved, and nursing staff, and perhaps other allied health professionals.

Neil Gray: The figure that I gave you was for doctors.

The Convener: That was for doctors only. So, for the entirety of the healthcare staff who may be involved if the bill passes, the training costs could be anticipated to be greater.

Neil Gray: I am happy to bring Ms Crossan in to give further detail. A lot would be dependent on the service model that is put forward. I know that the British Medical Association has raised questions about the model and how it will be established. The point that you raise is correct.

Nicki Crossan (Scottish Government): Those are indicative costs, which we have based on the assumption that around half of doctors will agree to participate in the service. We understand that there are conscientious objection clauses in the bill, so not all doctors would necessarily participate. That figure is based on half of doctors participating.

The Convener: Thank you very much for that clarity.

Emma Harper: Education costs would apply only initially, because once the service was established, training would be built into registered nurse training programmes as well as medical training. In other words, there would be an initial training cost, but then training would be built into future training programmes.

Neil Gray: Ms Harper is correct.

Brian Whittle: One of the main concerns around the bill is that, currently, one in four people does not have access to appropriate palliative care, which might influence their decision on whether to access assisted dying. Cabinet secretary, from your perception and in the Scottish Government's estimation, is palliative care good enough, or are you also concerned that lack of access to palliative care might have an impact on the bill?

Neil Gray: We have extensive policy positioning on this area. The consultation on our draft palliative care strategy has just concluded. We are considering the responses and expect to be able to publish the strategy later this year.

As Mr Whittle will have seen in the draft budget, we have put extensive additional funding—£21.7 billion—into health and social care services in general, and we expect local boards to ensure that adequate palliative care provision is available. We have also included a line for increased hospice care funding and a proposal to align pay and conditions in the hospice sector with the national health service agenda for change conditions, so that we can ensure that adequate palliative care is in place.

I am very grateful to the people in the NHS, the hospice sector, community and social care, and general practice who provide extensive palliative care support, whether in a hospital, someone's home, a care home or a hospice. The tireless efforts that they make to do so receive my extensive thanks. We, in the Parliament, have a role to play to help people to understand what palliative care is and is not and what interaction it has with the bill in order to ensure that stigma around palliative care and dying is addressed. With that in mind, we will look to ensure that we are doing everything that is possible to provide the palliative care support that people need and expect.

Brian Whittle: I appreciate that answer, cabinet secretary. Presumably, given what you just alluded to, if the bill is amended to include mandatory access to palliative care for anybody who is considering assisted dying—that is to say, that they must be offered palliative care at the same time—the Government would support a financial resolution to ensure that the bill could go ahead as amended.

Neil Gray: That would be a financial undertaking and we would need to consider that, should an amendment of that nature be made. It would be for others to determine whether such an amendment would be within the scope of the bill. I recognise the work of the likes of Miles Briggs, and we are considering how to ensure that palliative care support is as extensive and equitable as possible as part of our strategy. The work that we are doing in that vein, as well as supporting our hospice sector and our health and social care services, aims to ensure the availability of palliative care at the point of need.

10:30

Brian Whittle: You will recognise that, as many have said and as a number of witnesses have made clear in evidence to us, the concern is that those who might not have or get access to palliative care are pushed, unnecessarily, down the route of assisted dying. Do you share that concern?

Neil Gray: I have not had that concern expressed to me or suggested as a motivation behind someone supporting an assisted dying bill or otherwise. We will continue to make palliative care available as universally and equitably as we possibly can. I believe that, in the steps that we have taken in the proposed budget, we can see a continued improvement in that position with regard to the direct funding that we are seeking to provide to hospices, which, like many other social care providers, are facing a particular challenge with the likes of the increase in employer national insurance contributions that is coming down the

track. We are looking to support those organisations as best we can, while obviously wanting to see the UK Government resolve that matter at source.

As for the funding that we provide to our health and social care partnerships and our health boards, it is for them to direct where that goes, based on the demand being placed on them—in this case, with regard to palliative care services. We will continue to work with them to ensure that such care can be provided as universally and equitably as possible.

Brian Whittle: One of the big wins from this bill—if "wins" is the word that I am looking for—is that it is shining a light on palliative care provision and the need for it to be equitable across the country. If you look back at some of the evidence that we have heard, you will see the concern with regard to palliative care and the potential for some people to consider assisted dying because of inadequate palliative care in their particular instance. I ask you to have a look at that, because it is a big concern for me. I would like to think—and I am sure that you will agree with me—that, if the bill were to be passed, everybody who wished to consider assisted dying could also access palliative care, that the matter would be raised by a GP or whatever at the time and that provision would be equitable.

Neil Gray: I recognise that some might have raised that as a concern, but I hope that I have set out the steps that we are taking to try to address its being a concern. I would highlight the draft strategy on palliative care that is being consulted on and which seeks to improve the position in that respect, and the steps that we are taking in the budget to fund our health boards and our hospices to maintain or expand provision.

It is important to stress, too, that there is a belief, wrongly held by some, that palliative care is only for those with a short time left to live. Such care can—and, in many cases, should—be offered from the time that a person is diagnosed with a serious or life-threatening condition, because it can help them to get the right support in place, manage their symptoms better and allow them to think through the best treatment options, taking into account what really matters to them. That is the person-led approach that we want to see, and it can be offered alongside other treatments that aim to prolong their life.

Such care has to be bespoke and person led to ensure that we are addressing the needs of people as they see them. It is not just for those at the end of life. I hope that that provides additional clarity for the committee in considering whether that should be a factor in decision making.

Sandesh Gulhane: I declare an interest as a practising NHS GP and chair of the medical advisory group on the bill.

What is your opinion on the age limit of 16 in the bill? We were discussing with the last panel whether it should be 16 or 18 and it is a debate that we have been having throughout our evidence taking. What would your position be?

Neil Gray: I heard the evidence that was given earlier and I note the debate that is being had and the points that have been put across. I hope that Mr Gulhane will accept that I cannot put forward a position on the matter; it is for the committee and the Parliament to determine. As the lead minister on a bill on which the Government has taken a neutral position, I cannot influence people's consideration of the issue in any way.

Sandesh Gulhane: If the bill were to pass at stage 1, would the Government speak to the General Medical Council—in Scotland and UK-wide—about its position and how it could ensure that doctors are able to use the bill in a safe way, given the fact that, if they were to proceed, they would be open to people complaining about them with malicious intent?

Neil Gray: Yes. Should the bill pass stage 1, extensive discussions would need to be had with a number of stakeholders, and I would have a responsibility as health secretary to ensure that I was taking matters forward in the interests of health and social care services and the people who interact with them. I think that everyone would expect me to have conversations such as those that Mr Gulhane set out.

Sandesh Gulhane: Would you or the Government like to see anything in the bill about how the service would operate?

Neil Gray: I have noted some of the evidence that has been put forward. I understand the live debates that there are, which the committee will be considering, around the shape of any proposed service and how it would interact with existing health services. It is for the committee to determine that in its stage 1 report and for the Parliament to consider that. My position will remain neutral until that has taken place.

Sandesh Gulhane: Given your previous answers, you might not be able to answer some of my other questions. However, I would like some comment about the NHS's relationship to the potential service model should the bill become law. For example, should it be a separate service in the NHS or integrated into existing services?

Neil Gray: Again, I am trying to be as helpful as possible to Mr Gulhane and to the committee. I have set out in my opening statement that the Government is taking a neutral approach and that,

as the lead minister for the bill, it would not be appropriate for me to comment on provisions within it. I note the evidence that has come forward and I understand the debate that is there. We will all have to consider the matter should the bill pass stage 1.

Sandesh Gulhane: Should there be a register of people who are trained to perform assisted dying and are willing to participate in it, with a sort of opt-in system?

Neil Gray: I have seen some of the evidence from the likes of the BMA and some palliative care professionals in relation to that point. I understand the perspectives that have been put across. It will be for the committee to report on and for the Parliament to consider. Thereafter, the Government will take a firmer position on those topics.

The Convener: I want to go back to the financial memorandum on a point of clarity. The Government has looked at training time and costs in comparison with Mr McArthur's financial memorandum, and your response to Emma Harper's question was that you anticipate that, if the bill were passed, some pre-registration training would replace the training that would initially be needed as the bill was coming in. Would there be any scope to factor in costings for updates? What you learn pre-reg does not necessarily translate to something that you are doing in clinical practice five, 10 or 15 years down the line.

Neil Gray: I would be happy to take that point away and to write to you to give you what I can on the financial memorandum considerations.

The Convener: That would be great. Thank you very much, cabinet secretary.

Carol Mochan is joining us online.

Carol Mochan (South Scotland) (Lab): Cabinet secretary, I want to ask about ministerial powers. You may or may not be able to put anything on the record at this point, but I will give you an opportunity to do so. The bill contains 10 delegated powers provisions: nine regulation-making powers and one power to issue guidance. At this stage, does the Scottish Government have any comment about the scope of the regulation-making powers in the bill?

Neil Gray: I know that the Delegated Powers and Law Reform Committee, which is the regulatory committee, has considered that point. I cannot comment on it beyond what I have set out in the Government's memorandum. I hope that Ms Mochan will understand.

Carol Mochan: That is fine. Is there anything about what will be in the bill that you can comment on, particularly about subordinate legislation?

Neil Gray: Unfortunately not. Beyond what I have set out in the Government's memorandum, I must maintain a strictly neutral position to allow the committee and the Parliament to assess the merits of the bill on the basis of what I believe will be a universally free vote, including for those in the Government. My responsibilities as health secretary and lead member for the bill will come in should the bill pass stage 1, and then there will be far more extensive dialogue and discussion and policy positions taken.

Carol Mochan: That is helpful. Thank you, convener.

The Convener: I have some final questions, cabinet secretary. Again, there might be issues that you cannot comment on.

Neil Gray: I will try to be as helpful as possible.

The Convener: I appreciate that and the committee understands that you have set out the Government's position.

Does the Government have an opinion on the proposed five-year review period of the legislation or the suggestion that the bill should include a sunset clause?

Neil Gray: Not at this stage, no.

The Convener: Has the Scottish Government come to any decision or any conclusion about whether an oversight body should be convened to monitor the function of the legislation should the bill pass?

Neil Gray: Again, I understand that being a query and an area of interrogation for the committee, but the Government has not taken a position on that as yet.

The Convener: My final question is about section 17 of the bill, which would require that the terminal illness involved is recorded as the cause of death on the death certificate, as opposed to the administration of an approved substance that is associated with assisted dying. Is the Government perhaps looking with National Records of Scotland at how that might be recorded on a death certificate, given that that would deviate quite markedly from current practice, as we heard from earlier witnesses?

Neil Gray: I heard the evidence that the committee took this morning. I have not interacted with NRS on that issue, and I am not sure whether the committee has explored it with NRS, but it might be something to follow up on. We do not have a position on that as yet.

Paul Sweeney (Glasgow) (Lab): I appreciate the cabinet secretary and colleagues joining us. I have a point of interest on the matter that you discussed with colleagues earlier on legislative competence and the provisions set out by the

member in charge for potential remedies to the concerns raised by the Government. Does the Government have a view on a preferred remedy, even though it is hypothetical at this stage?

Neil Gray: I thank Mr Sweeney for his question and understand his reasons behind it. We have set out our position on legislative competence in our memorandum. I recognise that Mr McArthur has sought to propose options. Should the bill pass stage 1, we would look at what options might work. At this stage, there is nothing further for me to add.

Paul Sweeney: Could the Government perhaps address each of the options, whether it is section 30, section 63 or section 104, and outline what they might do, or would that be premature at this stage?

Neil Gray: For the Government, yes, that would be premature. We have nothing further to add, other than our position that we believe that elements in the bill would not pass legislative scrutiny and are not within our legislative competence.

The Convener: I have no indication of any more questions from the committee. I thank the cabinet secretary and his officials for their attendance.

Next week, the committee will conclude its programme of oral evidence as part of its stage 1 scrutiny of the Assisted Dying for Terminally Ill Adults (Scotland) Bill by taking evidence from the member in charge of the bill.

That concludes the public part of our meeting.

10:44

Meeting continued in private until 11:08.

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