END OF LIFE ASSISTANCE (SCOTLAND) BILL

EXPLANATORY NOTES

(AND OTHER ACCOMPANYING DOCUMENTS)

CONTENTS

1. As required under Rule 9.3 of the Parliament's Standing Orders, the following documents are published to accompany the End of Life Assistance (Scotland) Bill introduced in the Scottish Parliament on 20 January 2010:

- Explanatory Notes;
- a Financial Memorandum; and
- the Presiding Officer's Statement on legislative competence.

A Policy Memorandum is printed separately as SP Bill 38–PM.

EXPLANATORY NOTES

INTRODUCTION

2. These Explanatory Notes have been prepared by the Non-Executive Bills Unit on behalf of Margo Macdonald MSP, the member in charge of the Bill. They have been prepared in order to assist the reader of the Bill and to help inform debate on it. They do not form part of the Bill and have not been endorsed by the Parliament.

3. The Notes should be read in conjunction with the Bill. They are not, and are not meant to be, a comprehensive description of the Bill. So where a section, or a part of a section, does not seem to require any explanation or comment, none is given.

SUMMARY AND BACKGROUND TO THE BILL

4. The Bill is concerned with providing persons with a choice at the end of life. It is about ensuring that persons who meet the Bill's eligibility conditions and who find their lives intolerable can have the dignified death they desire.

5. The Bill details those persons eligible to apply and specifies the criteria to be met.

6. The Bill includes detailed requirements designed to ensure that vulnerable people are not coerced into seeking an assisted death.

7. The Bill enables eligible persons to receive assistance to bring about the end of their life. The Bill provides a detailed process with systematic checks and safeguards applying to both those assisting the person and the person making the request. If these processes are followed then the person will be able to receive an assisted death and those who have assisted will not have committed a criminal offence or a delict.

COMMENTARY ON SECTIONS

Section 1: Lawful to provide assistance under this Act

8. Section 1(1)(a) specifies that it will not be a criminal offence or a delict for a person to provide end of life assistance so long as it is provided in accordance with the Bill. Any person may provide end of life assistance in accordance with the requirements of the Bill, subject to certain exceptions referred to at section 11(4). "End of life assistance" is defined at section 1(2) as meaning assistance to enable a person to die with dignity and a minimum of distress. Such assistance may include the provision or administration of appropriate means of ending life.

9. Section 1(1)(b) specifies that to provide assistance, including assistance by participating in any step required by this Act**,** to enable another person to obtain or provide end of life assistance in accordance with this Act will not be a criminal offence or delict. This provision is designed to address assistance incidental to the main act or acts of end of life assistance covered by subsection (1)(a). Among other things the assistance covered by subsection (1)(b) may

include participation in any step required by the Bill; for example, where a person participates in the processes set out in the Bill as a witness, designated practitioner or psychiatrist.

Section 2: Need for two formal requests

10. This section makes clear that end of life assistance may only be provided where two formal requests for such assistance have been made to a registered medical practitioner and those requests have been approved by that practitioner.

11. Section 2(1)(a) states that end of life assistance can be provided only on the request of the person who wishes such assistance. The paragraph defines that person as the "requesting person", a phrase which is used throughout the rest of the Bill. It further specifies that before end of life assistance can be provided the requesting person must have made two requests to a registered medical practitioner. The paragraph defines the requests as the "first formal request" and "second formal request". Further provision relating to the first and second formal requests is made at sections 4 to 9 of the Bill.

12. Section 2(1)(b) sets out the requirement, that before end of life assistance can provided, both the first and second formal requests must be approved by the registered medical practitioner to whom the requests were made in accordance with the Bill. The requirements that must be met before approval can be made are detailed throughout the Bill.

13. Subsection (2) defines the registered medical practitioner to whom the first request is made as the "designated practitioner". This definition is applied throughout the rest of the Bill. To conform to the requirements of the Bill the designated practitioner must consider and approve both the first and second formal requests. Where the second formal request is approved, it must be that same practitioner who makes the formal agreement with the requesting person and is present at the end of life.

Section 3: Revocability of request for assistance

14. This section covers the revocability of a request for end of life assistance and the effect on any future requests.

15. Subsection (1) makes it clear that the requesting person may revoke their request for end of life assistance at any point, in any manner, to the designated practitioner. This revocation can be made at any time from the making of the first formal request to the point at which end of life assistance is being provided. Regardless of who is to actually provide end of life assistance, the revocation should always be directed to the designated practitioner.

16. Subsection (2) specifies that revoking a request does not preclude a further request for end of life assistance from being made. Regardless of what point the application had reached in the process, any subsequent request for end of life assistance would require the making of a fresh first formal request.

Section 4: Eligibility requirements

17. Section 4 establishes the eligibility requirements for making a request for end of life assistance. It contains limitations on age and a requirement for registration with a medical practice which apply to those seeking end of life assistance. It also provides the details of the medical and other conditions which must exist before end of life assistance can be provided under the Bill.

18. Section 4(1)(a) requires that the person requesting end of life assistance must be at least 16 years of age at the time of making the first formal request.

19. Section 4(1)(b) requires the requesting person to have been registered with a medical practice in Scotland for a continuous period of at least 18 months immediately prior to making the first formal request. Subsection (3) makes provision for persons who have had to alter their registered practice either as a result of relocation or for any other reason and provides that registration need not be with a single practice throughout the continuous 18 month period.

20. The medical requirements for eligibility are set out in subsection (2). Paragraph (a) states that one category of person that can make a request are those diagnosed as terminally ill. A person who is terminally ill is defined at subsection (4) as a person who suffers from a progressive condition and whose death can be reasonably expected as a consequence within 6 months. It will be for the designated practitioner to be satisfied of the likely life expectancy.

21. As well as having a terminal illness the person will also have to find their life to be intolerable. What constitutes life being intolerable is not further defined in the Bill. This leaves the test as a subjective one determined by the person themselves although they will be subject to psychiatric assessment including discussion of their feelings, reasons and the condition they suffer from.

22. The second medical condition related category of persons who may apply is set out at paragraph (b) of subsection (2). It covers persons who are permanently physically incapacitated to such an extent as to not be able to live independently and who find life intolerable. This will encompass persons who have been the subject of a trauma as well as persons with progressive and irreversible conditions, in each case provided the dependency and intolerability criteria are met. Like persons falling under the first category, persons falling within this category will also require to find their life intolerable (see paragraph 21 of these notes). Persons able to live independent lives without the need for any assistance would not, regardless of their incapacity or degree of intolerability, qualify under this provision of the Bill.

Section 5: Requirements relating to designated practitioners and psychiatrists

23. Section 5 imposes constraints upon who can act as a designated practitioner or psychiatrist with regard to the processes set out in the Bill For example in relation to the consideration and approval of formal requests, and the actual provision of assistance under the Bill.

24. Subsection (1)(a), read with subsection (2), disqualifies a person from acting as a designated practitioner or as a psychiatrist for the purposes of the Bill if that person knows they are a relative of the requesting person. "Relative" is defined at section 12 to cover specified relationships including parents, children, brothers and sisters, spouses and civil partners as well as others further removed.

25. Paragraph (b) of subsection (1), read with subsection (2), disqualifies a person from acting as a designated practitioner or as a psychiatrist for the purposes of the Bill if that person knows they would benefit from the requesting person's estate on that person's death or have another interest in that person's death. This restriction does not apply to any reasonable fees for work done in relation to the application or its assessment.

26. Paragraph (c) of subsection (1), read with subsection (2), disqualifies a person from acting as a designated practitioner or as a psychiatrist for the purposes of the Bill if that person knows they would have another interest in that person's death. This includes the situation where a person may not benefit directly from a person's death but they may nevertheless have an interest in it. For example, the situation where a person is not a beneficiary of the requesting person's estate but that person has a child who is such a beneficiary.

Section 6: Requirements relating to first formal request

27. Section 6 sets out requirements relating to the form and witnessing of the requesting person's first formal request for end of life assistance.

28. Subsection (1)(a) requires that the first formal request state it is a request for end of life assistance under the terms of the Act. Subsection (1)(b) requires that the first formal request must be in writing and signed by the requesting person as well as two witnesses. Any discussions or informal conversations seeking end of life assistance would not amount to a formal request for assistance under the Act.

29. Subsection (2) provides that in addition to acting as witnesses to the requesting person's signature the witnesses must also certify, that to the best of their knowledge and belief, the requesting person:

(a) understands the nature of the request;

(b) is making the request voluntarily; and

(c) is not acting under any undue influence in making the request.

30. Subsection (3) recognises that for those living in a care home the staff are likely through day to day contact to know the person well and be in a strong position to be able to certify under subsection (2). The subsection requires for those living in a care home that one of the witnesses to the first formal request must be an employee designated by the manager of that facility as an employee who knows the requesting person well. Paragraph (b) of subsection (3) makes it clear that the other witness cannot be an employee of the facility. If it is "not practicable" to identify a suitable employee willing to certify the terms of subsection (3) no longer apply. "Not practicable" would also cover any undue delays in identifying such a witness. A care home service is defined in section 12 by reference to section 2(3) of the Regulation of Care (Scotland)

Act 2001 (asp 8) as being a service which provides accommodation together with personal care, support or nursing.

31. Subsection (4) further restricts who can be a witness to the first formal request.

32. Subsection (4)(a) prevents the witnesses from being a relative of the person making the request. 'Relative' is defined in section 12, covering parents, partners, children, grandparents, brothers and sisters as well as less closely related persons.

33. Paragraph (b) prevents any person who would be entitled to any part of the requesting person's estate on their death from being a witness.

34. Paragraph (c) prevents the witness from being a person who would have another interest in the requesting person's death.

35. Paragraph (d) prevents the designated practitioner from witnessing a first formal request.

36. By virtue of subsection (5), the disqualifications in subsection (4) apply only if the witness knows of the benefit, relationship or interest involved.

Section 7: Consideration of first formal request by designated practitioner

37. Section 7 makes it clear that the designated practitioner cannot approve the first formal request unless certain requirements are satisfied.

38. Subsection (1) requires the designated practitioner to meet with the requesting person in person and sets out a series of matters which must be discussed before a formal request can be approved.

39. Subsection (1)(a) requires that the designated practitioner discuss the person's medical condition that qualifies them to make a request for assistance. That discussion will inevitably cover how that condition makes life intolerable.

40. Subsection (1)(b) requires the discussion to cover all feasible alternatives to end of life assistance including hospice care and palliative care.

41. Subsection (1)(c) requires the discussion to cover the nature of the request and the consequences that would follow if it were approved. In this context the designated practitioner is expected to stress the revocable nature of the request, thus ensuring that the requesting person is aware that they are in control and can revoke the request at any time right up until the point at which end of life assistance is provided.

42. Subsection (1)(d) requires the discussion to cover the options available with regard to the forms of end of life assistance which may be provided.

43. Subsection (2) details matters that the designated practitioner must be satisfied about before approving a first formal request.

44. Paragraph (a) requires the designated practitioner to be satisfied that the requirements of section 4 are met. Thus it falls on the designated practitioner to be satisfied that the requesting person is 16 years of age or over and has been registered with a medical practice in Scotland for at least 18 months prior to making the application. In addition, they must be satisfied that the medical condition falls within section 4 and the person finds life intolerable.

45. Paragraphs (b) and (c) require the designated practitioner to be satisfied that the requesting person is making their request voluntarily and is not acting under any undue influence in so doing.

46. Paragraph (d) requires the designated practitioner to have received a positive report from a psychiatrist acting under section 9 of the Bill. The role of the psychiatrist is further set out at section 9, together with a definition of "capacity" for the purposes of the Act (this definition can be found at section 9(4)).

47. Subsection (3) establishes that a positive report for the purposes of subsection (2)(d) is one which states that to the best of the psychiatrist's knowledge and belief the requesting person has the capacity to make the request, is making the request voluntarily and is not acting under any undue influence in making the request.

48. Subsection (4) requires that if the designated practitioner does approve the first formal request then the approval should be in writing, signed and dated and confirming that the requirements of section 7 have been met.

Section 8: Requirements relating to second formal request

49. Section 8 sets out the requirement relating to the making of a second formal request for end of life assistance.

50. Subsection (1) contains "threshold requirements". Subsections (2) to (4) contain the requirements of the second formal request.

51. Under subsection (1), a second formal request for assistance may not be made unless a first formal request has been approved by the designated practitioner, the requesting person has been informed of the approval of the first formal request and a period of not less than 15 and not more than 30 clear days have elapsed since the requesting person was informed. Failure to submit a second formal request within the 30 days period will have the effect of ending the process; where there is such a failure a second request could not be submitted, and a first formal request would have to be made afresh if the individual concerned still wished end of life assistance.

52. Subsection (2)(b) requires the second formal request to be addressed to the designated practitioner – that is, to the registered medical practitioner who received, considered and approved the first formal request.

53. Subsection (3) states that the provisions in section 6(2) to (5) and section 7 apply in relation to the second formal request (see paragraphs 29 to 48 of these notes). This means that the second formal request will be subject to the same requirements applicable to the first request, e.g. in relation to the form of the request, witnessing and the consideration of that request by the designated practitioner. Subsection 8(4) makes clear that the witnesses to the second request do not need to be the same as those to the first request.

Section 9: Consideration of capacity etc. by psychiatrist

54. Subsection (1) requires that a psychiatrist must meet the requesting person in person after the making of both first and second formal requests, discuss with them the matters set out in subsection (2) and report to the designated practitioner. A report is made to the designated practitioner covering matters set out subsection (3), including in particular an assessment of whether or not the requesting person had capacity to make the request.

55. Subsection (2) details matters to be discussed between the psychiatrist and the requesting person before the psychiatrist can make a report on that person's capacity to make a request.

56. Subsection (2)(a) requires that the psychiatrist discuss the person's medical condition (referred to in section 4(2)) that qualifies them to make a request for assistance.

57. Subsection (2)(b) requires discussion about the availability of all feasible alternatives to end of life assistance including hospice care and palliative care.

58. Subsection (2)(c) requires the discussion to cover the nature of the request and the consequences that would follow if it were approved. The requesting person should again be made aware of the revocability of the request. In addition, under subsection (2)(d), discussion should cover the options available with regard to the forms of assistance which may be provided.

59. Subsection (2)(e) requires that the psychiatrist discuss the requesting person's feelings and reasons for seeking end of life assistance. This requirement will likely include the effect their medical condition is having upon their life and the degree to which they find life intolerable.

60. The psychiatrist will be expected to make all other necessary inquiries of the requesting person's to enable them to assess and report on the person capacity to make and understand the request and its implications (see paragraphs 62 to 64 of these notes in relation to capacity).

61. Subsection (3) requires that the report must cover whether the requesting person has the capacity to make the request, whether the requesting person is making the request voluntarily and whether the requesting person is acting under any undue influence in making the request.

62. Section 9(4) sets out that a person has capacity to make a request if they are not suffering from any mental disorder which might affect the decision to make such a request. In addition they require to be capable of communicating, understanding and remembering such decisions. Understanding decisions includes being able to understand or remember information relevant to the decision, including information about the foreseeable consequences of deciding one way or another, or of failing to make the decision altogether.

63. Section 9(4), when read with the requirement to discuss, ensures that all reasonable efforts are made to communicate with the adult in an appropriate way before arriving at a decision on capacity. For example, the assistance of an independent interpreter who is familiar with the adult's means of communication could be considered. The use of equipment to assist communication could also be considered.

64. Mental disorder is defined at section 12 and the definition is the same as in section 328 of the Mental Health (Scotland) Act 2003: mental illness, personality disorder or learning disability however caused or manifested. In line with the 2003 Act, a person should not be regarded as mentally disordered by reason solely of, sexual orientation or deviancy, transexualism, transvestitism or dependency or use of alcohol or drugs nor does the definition cover people who simply act imprudently. People who are temporarily under the influence of alcohol or drugs are not to be regarded as mentally disordered.

65. Subsection (5) imposes further restrictions to those contained in section 5(1) on who can act as a psychiatrist for the purposes of section 9. Subsection (5) prohibits a psychiatrist who is a relative of the designated practitioner or a psychiatrist with a financial connection to the designated practitioner from acting. It also prohibits a psychiatrist who has acted as a witness to the first and/or second formal request from acting.

66. Subsection (6) makes clear that the psychiatrist who considers the second formal request can be, but need not be, the same psychiatrist who considered the first formal request.

67. Subsection (7) requires that the psychiatrist's report is in writing, addressed to the designated practitioner and is signed and dated by the psychiatrist.

Section 10: Agreement on provision of assistance

68. Section 10 details the requirements that must be agreed once the second formal request has been approved before end of life assistance can be provided.

69. Subsection (1) sets out requirements relating to the agreement on end of life assistance which must be concluded between the requesting person and the designated practitioner. They must agree: that end of life assistance is to be provided; who is to provide the end of life assistance; the place where that assistance to be provided; and the means by which that assistance is to be provided. Section 11(4) prevents those persons listed in section 5(1)(a) to (c) from providing end of life assistance.

70. Paragraphs (c) and (d) of subsection (1) concern the place where, and the means by which, end of life assistance is to be provided. By virtue of section 11(5) the place must be one to which the public does not have access at the relevant time. The relevant place could be one to which the public normally have access, so long as they are precluded from access at the time when end of life assistance is being provided

71. Subsection (2) requires that the agreement between the designated practitioner and requesting person be in writing, signed by both the requesting person and the designated practitioner, and dated.

72. Subsection (3) introduces a cooling off period by preventing the agreement from applying for at least two clear days after it has been concluded. Section 11(2) further restricts the authority under the Bill to the provision of assistance within a period of 28 days from the date when the requesting person was informed of the approval of the second formal request for assistance.

Section 11: Requirements relating to the actual provision of assistance

73. This section is concerned with the requirements relating to the provision of assistance.

74. Subsection (1) states that the assistance must be provided so far as reasonably practicable in accordance with the agreement made between the requesting person and the designated practitioner under section 10.

75. Subsection (2) restricts the period during which end of life assistance may be provided to a maximum of 28 days, commencing from the date when the requesting person was informed of the approval of the second formal request. During this period agreement under section 10 must be made and assistance cannot be provided within the first two days following approval.

76. Subsection (3) provides another check requiring the designated practitioner to be satisfied that the requesting person is still acting without any undue influence and still wishes to proceed.

77. Subsection (4) restricts who may actually provide end of life assistance by excluding those persons listed in section 5(1) (a) to (c). Section 5(1) covers relatives and persons who would benefit from or have an interest in the death of the requesting person (see paragraphs 24 to 26 of these notes). It does not, however, preclude persons listed therein from being present at the end of life.

78. Subsection (5) requires that end of life assistance can only be provided in a place that is private at the time when the end of life assistance is provided.

79. Regardless of who administers the means to bring about the end of life, subsection (6) requires that the designated practitioner be present when end of life occurs.

Section 12: Interpretation

80. Section 12 sets out definitions of terms which appear throughout the Bill all of which are explained earlier in these notes.

Section 13: Commencement and citation

81. Subsection (1) provides that the Act will come into force at the end of the period of 6 months beginning with the date of Royal Assent (apart from section 13 itself which commences on Royal Assent).

FINANCIAL MEMORANDUM

INTRODUCTION

82. This document relates to the End of Life Assistance (Scotland) Bill introduced in the Scottish Parliament on 20 January 2010. It has been prepared by Non-Executive Bill Unit on behalf of Margo MacDonald MSP, who is the member in charge of the Bill, to satisfy Rule 9.3.2 of the Parliament's Standing Orders. It does not form part of the Bill and has not been endorsed by the Parliament.

83. The purpose of the Bill is to provide persons with a choice at the end of life. It is about ensuring that persons can as far as possible receive a good and dignified death.

84. The Bill provides that, on the request of the person, and conditional on set requirements being adhered to, a person can receive end of life assistance.

ASSISTED DEATHS

85. There are no figures for how many people would be likely to seek an assisted death. During 2007 in Scotland 517[1] people committed suicide while in the case of a further 321[2], the case was undetermined as to whether they had actively taken their own lives. This, however, does not provide any indication of how many would have sought an assisted death if it had been available. It is possible that many of these people might not have committed suicide if they had been able to seek an assisted death and had the opportunity to discuss their situation and a range of possible options with a registered medical practitioner as required under the terms of this Bill. It is likely that many or most of the people who committed suicide would not have met the Bill's eligibility conditions, particularly those relating to terminal illness and physical incapacity.

86. In order to ascertain what the demand might be in Scotland, figures from those countries and territories where assisted dying has been legalised are drawn upon.

[1] General Register of Scotland
[2] General Register of Scotland

87. In 2008 in Oregon 60 people died as a result of assisted suicide. This represents a figure of 19.4 deaths per 10,000 deaths in Oregon. Since assisted suicide was implemented in Oregon in 1997, there have been 401 deaths resulting from assisted suicide,[3] an average of 36 each year. In total 363,758[4] people have died in Oregon in this 11 year period with assisted deaths representing 0.001% of all deaths.

88. In 2007 55,986 people died in Scotland.[5] Applying the above proportion of assisted suicide in Oregon to this figure provides an estimated figure of 55 assisted deaths each year in Scotland.

89. This figure can be tested against the experience of other jurisdictions with a broadly similar legal framework. Washington State legalised assisted dying at the end of 2008. Six people have been prescribed the necessary medication and to date only one has availed themselves of it.[6] In the two years assisted dying was available in the Australian Northern Territories, four people received an assisted death.

Margins of uncertainty

90. It is difficult to determine how the population of Scotland in general and the medical profession specifically will respond to a change in the law and as such there is uncertainty about the number of people who will apply for and receive an assisted death.

91. The figure of 55 provided utilises the information available from other countries and states. It is expected, given that experience that in the first years the number of people requesting assisted will be low. Evidence from Oregon would suggest that in subsequent years the numbers of people receiving assisted deaths will not increase markedly.

COSTS ON THE SCOTTISH ADMINISTRATION

92. There will be minimal if any costs incurred by the Scottish Administration.

93. The Bill does not require any public education campaign by the Scottish Government, however, should they wish to undertake such a campaign, then dissemination of the change in the law as regards assisted dying would be useful and welcome.

94. It is envisaged that the Scottish Government could prioritise any campaign on this Bill within existing public information budgets.

[3] 2008 Annual Report Oregon
[4] http://egov.oregon.gov/DHS/ph/pas/ar-index.shtml
[5] General Register of Scotland
[6] http://www.nytimes.com/2009/05/23/us/23suicide.html

COSTS ON LOCAL AUTHORITIES AND OTHER PUBLIC BODIES

Local authorities

95. There are not expected to be any direct costs upon local authorities resulting from the Bill. The main burdens will fall upon local Health Boards.

Health Boards

96. Much of the responsibility for assisting those who are seeking an assisted death will rest with local Health Boards. Given the small numbers, it is envisaged that the time and costs involved will not be significant.

Cost of means required to assist in death

97. The costs required to deliver an assisted death will be minimal and will inevitably be less than those associated with providing ongoing medication and care.

Costs on general practitioners' time

98. In 2007 there were 3,826 general practitioners in Scotland. Given that requests will be made to general practitioners, the bulk of the work in relation to assisted dying will fall upon those in practice.

99. Experience from other countries and territories suggests that time involved in considering requests varies from case to case. It is therefore difficult to predict how much of a medical practitioner's time will be devoted to considering requests for an assisted death.

100. Although there is a small number of predicted cases, it can be expected that the actual number initiating inquiries will be higher. It is, however, anticipated that the additional consultations can be subsumed into the existing workload.

101. It will fall upon the registered medical practitioners to counsel the person and advise them of available alternatives including palliative care. This nature of work is already part of a registered medical practitioners work, particularly when treating persons with severe depression and suicidal tendencies.

NHS Education for Scotland

102. The Bill will create initial training or information requirements for nurses, doctors, and the wider NHS. These costs are not expected to be significant, given that the staff in question are already involved in the overall care, counselling and contribution to assessment outcomes of those who may be eligible for assistance.

Crown Office Procurator Fiscal Service (COPFS)

103. COPFS has powers to examine all sudden, suspicious or unexplained deaths, and any deaths which occur in circumstances such as to give rise to public concern (section 1(1)(b) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976).

104. It can be expected that COPFS will consider each case of an assisted death and instruct investigations into the death. Under the terms of the Bill, it is likely that the procurator fiscal will pursue one of three courses of action.

- Take no further action. This could be the decision if the doctor reporting the death is prepared to issue a Death Certificate and the Procurator Fiscal is satisfied from the history reported that the death met the terms of the Bill and does not require further investigation.

- Request a police report. Where there is doubt as to whether the process specified in the Bill has been followed or the cause of death has not been ascertained or the Procurator Fiscal requires further information a police report is likely to be requested. The requesting of a police report does not mean that the Procurator Fiscal regards the matter as criminal. In such a situation the police act as agents of the Procurator Fiscal and gather information on his or her behalf. The Procurator Fiscal will almost always instruct a police report in a case where he or she anticipates instructing a post mortem examination.

- Consent to a hospital (non-PF) post mortem examination. Occasionally where the cause of death has not been certified, a hospital doctor will inform the Procurator Fiscal that the hospital has received permission from the relatives to carry out a post mortem examination. If the death does not otherwise require investigation the Procurator Fiscal will normally permit the hospital post mortem to proceed, subject to being advised of the cause of death.

105. COPFS already considers any sudden, suspicious or unexplained deaths, and any deaths which occur in circumstances such as to give rise to public concern. The information that will be recorded in the course of assisting a person to die under the terms of this Bill will be of assistance to any investigation conducted by COPFS.

106. Overall there will be an increase in workload for COPFS but when set against the 13,500[7] deaths reported to the COPFS annually, this is not considered to be significant.

COSTS ON OTHER BODIES, INDIVIDUALS AND BUSINESSES

Individuals

107. There will be some costs incurred by individuals requesting an assisted death.

[7] Correspondence from COPFS

108. The Bill does not prevent persons from requesting an assisted death from a registered medical practitioner working in private practice or to see a psychiatrist working in private practice. Time and availability may be significant constraints on who can be consulted. It is possible that while it may be possible to access an NHS general practitioner, time and availability constraints may mean it is less possible to see an NHS psychiatrist. It is difficult to predict what the cost of consultations with a psychiatrist may be particularly as it is difficult to estimate how many consultations a psychiatrist might require to be satisfied the person is capable of making the decision to receive an assisted death. In order to estimate a figure we have drawn on the advertised costs of a number of psychiatrists operating in the UK. Based on these figures and on the assumption that there might be four consultations, two for each request, the cost will be in the region of £675. This is considered to be up at the upper end of the potential costs and is unlikely to be higher.

MARGINS OF UNCERTAINTY

109. The estimates provided in the memorandum are the best available drawing upon experiences elsewhere. They could be affected by a wide range of factors from economic to the relative health and welfare across nations. Every attempt has been made to verify the base number by reference to and comparison with a range of available jurisdictions.

110. The costs to the public purse are considered negligible when compared with ongoing costs and the time involved may well be less then would otherwise have been expected.

111. While it is accepted the numbers involved are subject to significant uncertainty it is considered that the cost per individual provided is at the upper end. Overall it is not considered that there will be costs imposed on the public purse as a consequence of this Bill.

PRESIDING OFFICER'S STATEMENT ON LEGISLATIVE COMPETENCE

112. On 20 January 2010, the Presiding Officer (Alex Fergusson MSP) made the following statement:

> "In my view, the provisions of the End of Life Assistance (Scotland) Bill would be within the legislative competence of the Scottish Parliament."

These documents relate to the End of Life Assistance (Scotland) Bill (SP Bill 38) as introduced in the Scottish Parliament on 20 January 2010

END OF LIFE ASSISTANCE (SCOTLAND) BILL

EXPLANATORY NOTES

(AND OTHER ACCOMPANYING DOCUMENTS)

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