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East Lothian Council
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Additional information:

This is a copy of a response made at officer level to a request from the Scottish Parliament Health and Sport Committee for views on the Assisted Suicide (Scotland) Bill

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Dear Committee Members

**Call for Written Views - Stage 1 consideration of the Assisted Suicide (S) Bill**

I refer to your call for written evidence dated 14 March. This is a response from East Lothian Council, made at officer level.

We welcome the opportunity to respond to the consultation on the Assisted Suicide (Scotland) Bill. We carried out an internal consultation which involved all social workers, mental health officers, occupational therapists and community care assistants in the Council's Adult Wellbeing service.

This response aims to provide an overview of the range of views shared, identifying issues and themes which were prevalent throughout. Thoughts from individuals or groups could be at extremes, and opposing, but what was consistent throughout was that there are concerns about the Bill lacking in safeguards, detail and tight procedures. The Bill is considered to have inadequate safeguards if it is to progress and be implemented safely.

I am sorry this response does not fit within your 2,000 word limit, but I hope when you read it you will understand why.

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

As can be expected, a wide range of complex individual perspectives were shared. These ranged from those who considered that to make it permissible to assist another to commit suicide is acceptable and humane and that this Bill is too limiting in its consideration, to those who under no circumstances believe that the law should legalise assisting another to end their life. Should this Bill progress, this range of

beliefs and perspectives need to be considered and respected in the development of any policies, guidelines and code of practice.

Concerns were shared that supporting the purpose of this Bill is justifying the beginning of a shift away from ensuring energies and priorities go in to progressing treatments and the provision of good quality care to improve the quality of life for those who do have progressive or terminal conditions. Concerns that there might be a move away from the therapeutic aspects of palliative care

Considering the Social Worker role and professional identity, the following is presented as evidence that this Bill does not comply with their professional ethics and nationally recognised standards. The Scottish Social Services '*Council Code of practice for Social Service Workers and Employers*' promotes in their section referring to Social Service Workers that:

- 4 As a social service worker, you must respect the rights of service users while seeking to ensure that their behaviour does not harm themselves or other people
- 4.3 Taking necessary steps to minimise the risks of service users from doing actual or potential harm to themselves or other people.

Referring to the British Association of Social Workers '*Code of Ethics for Social Work-Statement of Principles*', ethical practice principle 8 *Challenging the abuse of human rights* states that 'Social workers should not collude with the erosion of human rights....'. Article 2 of the European Convention on Human Rights provides that: 'Everyone's right to life shall be protected by law'. Supporting a Bill which promotes legalising assisting another to commit suicide was considered in opposition to Social Work ethics.

In contradiction to the above, 'the Code of Ethics for Social Work-*Values and ethical principles*' was used to support that the purpose of this Bill is not contradictory to Social Work principles. 'Respecting the right to self-determination' (Principle 2) states that Social Workers should "...respect, promote and support people's dignity and right to make their own choices and decisions, irrespective of their values and life choices...".

Throughout the consultation, irrespective of individual beliefs or interpretation of how Social Work principles can be considered in relation to this Bill, there was consistency in that this Bill is thought to lack detail and sufficient safeguarding. Given the enormity of the purpose of the Bill, there was a lack of 'tightness' in how the Bill should be implemented leaving the person seeking assistance and those involved in providing the assistance vulnerable and exposed to error or poor practice. These are particularly in relation to the assessment of capacity, tight procedures and protections for all parties. Discussions around these issues are detailed more fully below.

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

The previous End of Life Assistance (Scotland) Bill was considered by Margo Macdonald in her proposal paper 2012 to be 'robust but cumbersome'. This Bill has therefore been proposed as a 'more straightforward process' and has been successful in its aim. However, in making the process more 'straightforward' our internal consultation suggests that some of the changes may leave the present Bill without sufficient safeguards. This is particularly relevant in relation to the belief of relevant officers that a full assessment of capacity should be part of the staged process. In making this Bill more 'straightforward', a crucial safeguard has been omitted.

Moving away from the 'designator practitioner' being a medical practitioner (the role is now referred to as a 'facilitator') may allow for a more personalised and possibly informal end of life. However a likely consequence of this is the lack of expertise that could alleviate a potentially difficult, stressful or traumatic situation. While our internal consultation did not support the idea that a facilitator should necessarily be a medical practitioner, the point was made that a medical practitioner should be on hand to ensure that medical support is available on request and with immediacy; this is considered essential and should be stipulated in the Bill.

The previous End of Life Assistance (S) Bill eligibility requirements include someone who is 'permanently physically incapacitated to such an extent as not to be able to live independently and finds life intolerable' (Sec 4(2)(b)). Some participants of our internal consultation are of the opinion that this should not have been removed, however, as this was not consistently supported further fuller discussion of this would be needed. Very tight criteria would need to be applied if this were to be added to the existing criteria.

Omitting the maximum time scales at each stage is generally supported, as is the introduction of a 'preliminary declaration'.

Concerns about the person being coerced into ending their life is acknowledged throughout the discussion papers and debates around the previous Bill. As is shared throughout this consultation, these concerns continue. Examples of the practices in Oregon and Switzerland suggest that this has not been the case and no evidence of coercion has been found - in fact, usually the opposite with family members struggling with this decision. While this presentation is not being disputed, what is shared are the concerns about evidencing coercion – coercion can be subtle and complex with third parties finding it very difficult to prove.

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

Part 1 of the Bill clearly precludes any criminal and civil liability for those providing assistance under this Bill, so long as processes and requirements have been adhered to. The licensed facilitator is “to use best endeavours” to carry out their functions and Section 24 allows for ‘Savings for certain mistakes and things done in good faith’ by those ‘assisting’ or making ‘statements’. How these premises are proved raised concerns, with the belief that actions could be left open to interpretation. Tighter procedures would be desirable, ensuring clarity around the actions or omissions that would not be in keeping with this Bill. If tighter procedures are not adhered to, criminal proceedings should be initiated. Given the seriousness and finality of the purpose of this Bill, “to use best endeavours” was felt to be vague and allow scope for complacency.

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

While there are three clear stages, concerns were raised about the lack of detail at each stage. Reflecting on the Adults with Incapacity (Scotland) Act 2000 and the Mental Health (Care and Treatment) (Scotland) Act 2003, both clearly state what assessments and reports should be completed and by whom, the time scales for completion and who should be consulted at each stage of the processes. This Bill does not afford the same detail and more ‘checks and balances’ are requested to help ensure the person, the facilitator and others involved in assisting are protected. The following is proposed:

- An assessment of capacity should be standard at each request for assistance
- The assessment of capacity should be led by a consultant skilled in this area, but should be informed by a multi-disciplinary team.
- A counselling session and discussion at the point of the 1<sup>st</sup> request being made. The purpose being to ensure that the person has given full consideration to all the implications of their decision and to ensure that the person’s poor quality of life is not as a consequence of poor care or reduced access to drug treatments as might be available elsewhere. Evidence demonstrating that the person has considered other end of life and palliative care options need to be recorded.
- The two endorsements by medical practitioners should be completed within a certain time limit – 5 days is proposed.
- One of the endorsements should be completed by a ‘specialist medical practitioner’.
- Further detail of process at the Act of Suicide – how, who and when the ‘means’ would be obtained, where it would be stored before the act of suicide takes place and who is responsible for ensuring that this is done safely. Should someone else come to harm in that intervening period as a result of having access to the ‘means’, it is assumed that criminal proceedings would ensue. Clear information about what are acceptable ‘means’ is sought.

- Cancellation – if the 2<sup>nd</sup> endorsed request is cancelled in writing, it is proposed that this automatically cancels the 1<sup>st</sup> request. The thinking behind this is that the cancellation implies hesitation and uncertainty. In that frame of mind the person may be more vulnerable to coercion, and be easily encouraged to make a new 2<sup>nd</sup> request. Starting again with a new 1<sup>st</sup> request ensures that the person has safeguards in place and more protections in place.

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

Colleagues generally agreed that the Bill should provide criteria, and having a ‘terminal or life-shortening illness, or a progressive condition which is either terminal or life-shortening’ was not challenged. While the difficulty in determining how long someone might have to live, when their condition is considered to be terminal is widely recognised. The implications of this within this Bill, and being the criteria for its implementation, are significant and not resolvable. Whether those with chronic, debilitating and painful conditions should be included was discussed. With quality of life being assessed, this group of people sometimes have significantly reduced quality of life with no indication of improvement and more than likely deterioration with significant impact on their mental health.

Further detail and a tighter definition are sought.

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

Age: both the ‘person’ and the ‘facilitator’ being at least 16 years of age is considered too young as a minimum age. The enormity of the decision making and the potential impact on individuals who facilitate are significant. While age is not the only factor which ensures a degree of maturity or better informed decision making, it is anticipated that increasing the minimum age further enables this.

Capacity: concerns about the lack of procedural clarity around the assessment of capacity were raised throughout. The explanatory notes, part 28, states that ‘it is open to a medical practitioner dealing with a first or second request to seek any specialist input he or she feels is needed to inform his or her assessment.’ This was considered too flexible. Colleagues believe that the person’s capacity should be assessed at each request stage. This should be a multi-disciplinary assessment, led by psychiatry or someone with skills and experience in assessing capacity. The assessment of capacity is complex, as those who practise under the Adults with Incapacity (S) Act 2000 and the Mental Health (Care and Treatment) (S) Act 2003 were able to reflect. Capacity is not all-encompassing, may be impacted on by prescribed drug use, and may fluctuate in its presentation. Ensuring a full assessment of capacity would further safeguard the person and help to protect against undue pressure by others. The discussion considered other situations where

an assessment of capacity is essential, for example under Adults with Incapacity, and felt that the lack of an essential assessment in this Bill was not proportionate to the decision being made.

Connection with Scotland: this was generally considered as appropriate.

**7. Do you have any comment on the roles of medical practitioners and pharmacists as provided for in the Bill?**

In relation to both, concerns were expressed about their code of ethics and how their roles in the Bill would challenge this. It is hoped that they would contribute to this consultation and their responses will be read with interest.

Consideration was given to 'specialist medical practitioners'. The Mental Health (Care & Treatment) (S) Act '03 stipulates when a medical report should be completed by an 'approved medical practitioner' and that those practitioners will have certain qualifications and expertise. Having a similar system in place would afford further protection to the person and to the medical practitioners. While the number of requests for assisted suicide is unknown, it is likely that it will be small and that the medical practitioners will either never participate in this process or may only participate very infrequently throughout their careers. If this is the case, it is difficult for individuals to develop expertise and confidence in their contribution to an emotive and significant process. Stipulating that a 'specialist' practitioner must endorse one of the two requests at each stage would help to ensure some protection for all parties involved.

There is no reference to the medical practitioner's participation or role at the act of suicide, unlike the previous Bill. It is proposed that the facilitator informs the police of the person's death, or attempted suicide. We have assumed that a medical practitioner would certify the person as dead before the police are informed, but further participation or responsibilities are not referred to. Colleagues propose that the Bill states that medical support be made available as required and with immediacy, as standard practice.

The Bill does not state if the community pharmacist would dispense the drugs as prescribed by the medical practitioner. It is proposed that consideration is given to a 'specialist pharmacist', as in keeping with that proposed for medical practitioners and for the same reasons. While those nurses and medical practitioners who have cared for the person in relation to their illness or condition are disqualified from the role of facilitator, the community pharmacist may well have supported the person and dispensed their drugs for a significant period of time. It is proposed that similar consideration be given to disqualifying them from dispensing the drugs used in the act of suicide.

Being specific about who takes on the role of pharmacist, in accordance with the Bill, would ensure they are trained and fully aware of the procedures as stipulated in this legislation. It also allows consideration to be given to those pharmacists who have religious and moral beliefs which are contradictory to the purpose of this legislation.

**8. Do you have any comment on the means by which a person would be permitted to end his/her life under the Bill?**

The policy memorandum, section 38 states that ‘...it is envisaged that....the person’s GP will prescribe for them drugs suitable to enable them to end their life painlessly’. Other than this the bill does not give any guidance or instruction on methods which may be used. This is thought to be inadequate and further information is requested.

**9. Do you have any comment on the role of licensed facilitators as provided for in the Bill?**

Schedule 4 refers to those relationships disqualified from being a witness, proxy and licensed facilitator. Medical and nursing relationships that have provided treatment or care for the person in relationship are identified as being disqualified. There is no reference to carers, social workers, occupational therapists or others who have worked with the person in relation to their illness or condition. Why they are not included in those disqualified was questioned. To ensure independence and neutrality, colleagues thought they should be disqualified.

If they are not to be disqualified, there would be implications for Councils in the possible activities of their staff and the corporate risks this might involve. There might be undue pressure on individuals, from clients who wish assistance under the Bill to end their own lives.

As already stated, the lower age limit of 16 years is thought to be too young.

There is no mention or reference to how the licensing authority would be monitored or inspected. It is proposed that those agencies or bodies who become licensing authorities should be monitored, as any other provider of a service would be, through an independent body.

It was noted that the Bill clearly states that the act of suicide ‘must be...that person’s own deliberate act’ yet the general purpose of the Bill is ‘to assist another to commit suicide’, which is potentially contradictory. What is considered to be ‘that person’s deliberate act’ was extensively debated by colleagues. In the day to day care of older people or those with disabilities, the complexities of what is considered to be ‘prompting’ or ‘assisting’ someone with their medication can be difficult to define. This debate considered the implications of this for someone who is significantly debilitated by their condition with significantly reduced motor control. If the person and the facilitator are to be protected, what is considered the ‘person’s own deliberate act’ needs to be very clearly defined. More detail is requested.

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

As with many of the other discussions, responses varied from questioning why police were involved at all to why they were not involved throughout the proceedings.

Part 1 of the Bill, section 1 states 'No criminal liability for assisting suicide' so long as the requirements of section 3 are complied with. To report to the police was thought to be contrary to the intention behind the Bill. Others thought that reporting the assisted suicide would be in keeping with the reporting procedures when a suicide takes place. To ensure better protection for all parties involved, the consultation raised that the police should be informed of the intentions at the point of endorsement of the 2<sup>nd</sup> request. If the purpose of informing the police is to allow them to establish any criminal activity, informing them earlier in the process would better facilitate this.

While our internal consultation did not clearly support any one of the above, a larger number of those who contributed supported the need for further safeguards. Informing the police of the intentions to assist someone to end their life is one further way of enabling this.

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

As already stated, our internal consultation raised many opposing perspectives and views, with individual and professional values being challenged throughout. However, throughout the consultation, certain themes and areas of concerns did reoccur. These particularly included the need for more safeguards and tighter procedures to protect all parties. One safeguard which was strongly supported was the assurance that an assessment of capacity by a professional with appropriate skills should take place as standard practice.

The Bill does not address the issue of coercion. Experience of practising under the *Adult Support and Protection (Scotland) Act 2007* often raised issues around how difficult it is to evidence coercion and undue pressure. Those concerns were often raised in this consultation; those who feel a burden to families and loved ones may be vulnerable to subtle persuasion to make the decision to end their life which would be very difficult to prove.

There will be training needs, beyond those directly involved with the implementation of the Bill. Training will be required for those in caring or supporting roles to individuals who may be considering seeking assistance to commit suicide, or who have made that decision and are acting on it. Whose responsibility it is to provide this training has not been made clear. Support needs for family and loved ones of the person will be significant before, during and after the act of assisted suicide. Although the facilitator will have a role here, it is not clear if they will remain involved beyond the completion of the assisted suicide. Considering possible financial costs for the person, questions were raised about how this might be funded and if Self Directed Support would be used. The above are areas which need to be considered and have not been addressed in the Bill. A code of practice may address this need.

Another issue is Councils' role as Corporate Parent to Looked After Children and Young People. Councils' responsibility to these young people continues well beyond the age of 16, and it would be useful to consider in this respect how the provisions of this Bill fit with the provisions of the Children and Young People (Scotland) Act 2014.

I hope the Committee find these comments useful. Thank you for the opportunity to contribute to your thinking on this important and emotive topic.

Yours sincerely

A handwritten signature in black ink that reads "David Small". The signature is written in a cursive style with a large, prominent 'D' at the beginning.

David Small  
Director of Health and Social Care, East Lothian