# *A Human Right to Suicide Prevention: Analysis of 'The Impact of the Terminally Ill Adults (End of Life) Bill III'*

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## About the Author

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## Executive Summary

The Memorandum presents the Government's view that the Terminally Ill Adults (End of Life) Bill is compatible with the European Convention on Human Rights (ECHR). However, the Memorandum is not a statutory 'statement of compatibility'.

A major flaw in the Memorandum is that it fails to consider suicide prevention. The right to suicide prevention under article 2 of the ECHR should have been the starting point.

The Memorandum presents capacity, as defined in the Mental Capacity Act, and freedom from coercion by another person, as key safeguards. However, the Memorandum fails to consider the Mental Health Act, which is relevant in the context of suicide. It also neglects coercion due to social pressure. The Bill would allow a person who was suicidal as a result of a treatable mental illness to be offered the means to end their life. For this reason, the Bill may be subject to challenge under the ECHR.

The Bill's review process may also be subject to challenge as it provides for an appeal that could lead to loss of life but not for an appeal that could protect life.

It is not clear if the conscience clause is adequate to defend professionals' article 9 rights, but the lack of institutional protection leaves hospices, including religious hospices, with no legal way to avoid becoming suicide clinics.

Furthermore, if assisted suicide is legalised for some categories of patient, the right to non-discrimination (article 14) could be used to expand this to other patients. This is what has happened in other countries.

# A Human Right to Suicide Prevention: Analysis of 'The Impact of the Terminally Ill Adults (End of Life) Bill III'

## Introduction

The Department of Health and Social Care has produced two impact assessments of the Terminally Ill Adults (End of Life) Bill (the Bill) and a related Memorandum. The first is principally concerned with financial costs and cost reductions of implementing the Bill ('financial IA'). **[1]** A second concerns the impact on equality law ('equality IA'). **[2]** Alongside these two, the Department Health and Social Care and the Ministry of justice have issued a Memorandum on whether the Bill is compatible with the European Convention on Human Rights ('Memorandum'). **[3]** The current paper focuses on the Memorandum. It is the third of three papers on the three documents. **[4]**

## Not a Statutory 'Statement of Compatibility'

The Memorandum presents the opinion of the Government that 'the Bill is compatible with the ECHR [European Convention in Human Rights]'. This assessment is based primarily on the fact that 'the European Court of Human Rights (ECtHR) has afforded a wide margin of appreciation to states when considering end-of-life matters.' The ECtHR has held the current ban on assisted suicide in England and Wales is compatible with the ECHR. However, it has also held that the Belgian law on euthanasia is compatible with the ECHR. **[5]** Note that Belgium allows not only assisted suicide (where the lethal dose is self-administered) but also euthanasia (where it is administered by another person). Belgium also allows assisted suicide and euthanasia for minors and for people who are not dying but who have chronic physical or mental illness. The Belgian law is more expansive than the provisions on the face of the Bill, and if the ECtHR held the Belgian law to be compatible with the ECHR, it seems reasonable to believe that the ECtHR would also hold the Bill to be compatible.

Furthermore, 'domestically, the Government is of the view that very considerable respect will be accorded to the judgements made by Parliament in primary legislation'. **[6]** If Parliament passed legislation to permit physician assisted suicide for people with a terminal illness, subject to procedural requirements then, on the basis of case law **[7]**, it seems likely that domestic courts would hold this law to be compatible with the ECHR.

Nevertheless, laws in this area have been subject to legal challenge, and such challenges have sometimes resulted in legal or procedural changes. **[8]** Stephen Kinnock MP, speaking for the Government during Report Stage, argued that an amendment which aimed to protect people with learning disabilities 'may be subject to challenge under various international agreements, including... article 14 of the European Convention on Human Rights, which prohibits disability discrimination'. Note that the Minister did not express the view that the amendment was incompatible with the ECHR but only that it 'may be subject to challenge'.

The Memorandum acknowledges that, as the Bill is a Private Member's Bill, it falls outside the provisions of the Human Rights Act 1998 which

requires that a Minister of the Crown in charge of a Bill either provide a 'statement of compatibility' or acknowledge that one cannot be provided. The Memorandum is not a statutory 'statement of compatibility' but is an expression of the view of the Government. In this context, it would have been more helpful for the Government to consider whether provisions of the Bill 'may be subject to challenge' rather than giving its view as to whether the Bill was compatible or incompatible. The danger of the latter approach is that, in effect, the Government has constructed a defence of the Bill, of a kind that would be given were it a Government Bill. This does not help Parliament to identify and address aspects of the Bill that, from the perspective of human rights, are potentially open to challenge.

## Article 2 and Suicide Prevention

The Memorandum, having summarised the contents of the Bill, begins discussion of human rights in relation to the Bill with article 2; the right to life. **[9]** The Memorandum is clear, in a way that the two Impact Statements are not, that the law on assisting suicide engages with a person's right to life. **[10]**

A weakness of the Memorandum at this point, a weakness shared by the other two impact Statements, is the omission of any overt discussion of 'suicide prevention'. Nowhere in over two hundred pages does any of these three documents use this term or refer to the public policy objective of preventing suicide. The financial IA does not consider the impact of the Bill on the effectiveness of the national suicide prevention strategy. The equality IA does not consider equality of opportunity to access suicide prevention. The Memorandum does not consider the human right to be prevented from dying by suicide.

The neglect of the importance of suicide prevention in these documents is in contrast with the written evidence to the Public Bill Committee where over one hundred submissions raised the issue, in some cases as the primary focus of the evidence. **[11]** One submission begins, 'The provision of legal assisted suicide within the Terminally Ill Adults End of Life Bill (The Bill) is in direct opposition to the updated Suicide Prevention Strategy.' **[12]** Another argues that, 'the Bill permits someone with a wish to end their own life to be provided with assistance to do so (Clause 1) – i.e. to die by suicide. This falls within the scope of the current suicide prevention efforts, which aim to discourage and prevent individuals from ending their own lives, and it is difficult to see how it can be enacted in a way compatible with these efforts.' **[13]** Similarly in oral evidence, Professor Allan House argued that 'we would have to change our national suicide prevention strategy, because at the moment it includes identifying suicidal thoughts in people with severe physical illness as something that merits intervention, and the intervention is not an intervention to help people proceed to suicide.' **[14]**

In relation to the ECHR, Professor Jonathan Herring has argued that, 'a suicide involves a breach of Article 2 of the European Convention on Human Rights' and that 'the state has an obligation to protect citizens from breaches of their human rights'. **[15]** The positive duty on the state to do what it reasonably can to prevent suicide explains the prohibition on 'encouraging and assisting suicide' in the Suicide Act 1961 (as amended). **[16]** It also explains the provisions of the Mental Health Act 1983, including the provision, subject to strict procedural safeguards, for treatment to be given against the will of the patient. **[17]**

Beyond legal provisions in Acts of Parliament, the state also has a duty to take practical steps to

prevent suicide. Arguably the state would be failing in its positive duties under article 2 if it did not have a national suicide prevention strategy in place.

A key question in relation to assessing the compatibility of the Bill with the ECHR is whether the Bill would adversely affect efforts to prevent suicide. Such a concern has at least three forms: that a patient ending their life under the Bill itself constitutes suicide; that a person ending their life under the Bill could constitute suicide, for example if the wish to die were a consequence of a mental illness; and that the implementation of the Bill might 'normalise' or otherwise encourage suicide outside the provisions of the Bill ('conventional' or 'unassisted' suicide).

On the other hand, some have argued that 'assisted dying' can be an alternative to suicide and thus act as 'a form of suicide prevention'. **[18]** This argument is not cited in the Memorandum but it is alluded to in the financial IA.

> *In the UK, evidence suggests that some people with severe health conditions and / or a terminal illness may seek ways to end their own life… experimental statistics published by the ONS found elevated rates of suicide among people with severe health conditions (compared to those without)*. **[19]**

The financial IA states that the 'impact of VAD service provision in England and Wales on these outcomes [suicide in people with severe health conditions] is uncertain'. **[20]** However, while subject to uncertainty, there is evidence which can be cited. A recent study of people with cancer in Switzerland over a twenty-year period found that while the number of assisted suicides had doubled every five years there had been no reduction in unassisted suicides over the period. **[21]** No study that controls for sociodemographic factors has found a reduction in unassisted suicide associated with assisted dying/ assisted suicide/ euthanasia. Most studies have found large increases in self-initiated death and small increases, that are not statistically significant, in unassisted suicide. **[22]** One recent study has found a statistically significant increase of 6% in unassisted suicide following legalisation of physician-assisted suicide in the United States. **[23]**

All those who would die under the provisions of the Bill have their lives shortened by days, weeks or months (or, in the case of misdiagnosis, potentially by years). This shortening of life potentially breaches the patient's article 2 right to suicide prevention. However, whether, from the perspective of suicide prevention, all deaths under the Bill should be regarded as suicide, is contentious. Less contentious is the claim that some patients who seek assisted death may be suicidal, for example in that their decision is affected by a treatable mental illness. This issue is not dealt with adequately in the Bill, as there is nothing in the Bill that prevents a suicidal person who would benefit from, but is not receiving, mental health treatment from being offered the means to end their life. In relation to its failure to address the issue of suicide prevention, the Bill may be subject to challenge under the ECHR.

## Article 2 and 'particularly important safeguards'

The Memorandum fails to explore what is arguably the key context for the Suicide Act 1961, and thus for the Bill, which is the right to suicide prevention. Rather, it considers that the duties of the state under article 2 are addressed by the 'safeguards' in the Bill. After listing clauses which include safeguards the Memorandum concludes:

*Overall, the Government considers that the combination of these safeguards is sufficient to ensure that that an individual's decision to end his or her life is taken freely and with full understanding of what is involved and to prevent interference with article 2*. **[24]**

The Memorandum then highlights three safeguards which are deemed 'particularly important': 'capacity' **[25]**, 'freedom from pressure' **[26]** and 'review and judicial oversight'. **[27]**

**Capacity**

The reliance of the Bill on the test of capacity, as set out in the Mental Capacity Act 2005, excludes some actions that would clearly be contrary to human rights. However, the test for mental capacity does not provide protection for people who are suicidal, even where their suicidality is influenced by an underlying mental health condition. For this reason, the Code of Practice to the Mental Capacity Act 2005 specifies that someone with capacity does not thereby have a right to refuse treatment that is authorised by the Mental Health Act 1983. **[28]** The Mental Capacity Act is qualified by the Mental Health Act precisely in a context where someone's state of mind might pose a danger to 'his own health or safety or with a view to the protection of other persons' (and thus to the person or others' article 2 rights). **[29]**

A wish to strengthen the Bill, so that it does not rely so heavily on the test for mental capacity in the Mental Capacity Act (with its presumption of capacity) need not be seen as substituting a different definition of capacity from that 'which is already well understood by doctors and judges'. **[30]** It is simply that, as with the Mental Health Act, the determination of decision-making capacity is not regarded as sufficient for making decisions that are both prejudicial to life and influenced by a treatable mental illness. In this context, mental capacity is not regarded as sufficient grounds to honour a refusal of medical treatment for mental illness. On the same basis, mental capacity should not be regarded as sufficient grounds to obtain the means to end one's own life where the request is influenced by mental illness.

In the view of the Anscombe Centre, the Bill may be subject to challenge because the protection of the life of someone who is danger to their own health or safety, for reasons of a treatable mental ill health condition, is absent from the Bill.

It is noteworthy that the Royal College of Psychiatrists has voiced its own concerns about the use of the Mental Capacity Act in this context:

*The MCA* [Mental Capacity Act] *is used largely in the context of medical treatment decisions. It requires assessors to assume capacity as a starting point; incapacity must be proven. Assessing clinicians are also under a duty to support a person to make the decision in question. The presumption of capacity may be problematic in the context of AD/AS [Assisted Dying / Assisted Suicide] given the consequence, if the person is deemed capacitous and meets all other eligibility criteria, would be the person's death… It is the RCPsych's view that the MCA is not sufficient for the purposes of this Bill*. **[31]**

This concern has recently been reiterated by the Royal College of Physicians:

*We share the concerns expressed by the Royal College of Psychiatrists on the limitations of the current Mental Capacity Act and its use in this situation*. **[32]**

**Freedom from pressure**

In relation to coercion the Government notes that the ECtHR accepted the law in Belgium as compatible with the state's positive obligation

under article 2 in part because that law requires the request for euthanasia to be 'made of the patient's own free will, in a considered and constant manner, and is not the result of external pressure'. **[33]** The Government argues that:

> *The phrase 'external pressure' in the Belgian law is arguably slightly wider, and thus may offer marginally greater protection than the phrase 'by any other person'. However, any distinction appears minimal*. **[34]**

This distinction may appear minimal to the Government. However, narrowing the definition of external pressure in the Bill to pressure or coercion 'by any other person' leaves out arguably the most significant form of pressure that leads people to seek their own death. The words of the Equality and Human Rights Commission need to be given full weight:

> *It is also necessary to consider coercion beyond the risks posed by individuals. One of the most important protections against people feeling coerced into seeking an end to their life is to ensure social conditions, support, care and services are in place so that people with disabilities or serious or terminal illnesses do not feel that they are a burden to their loved ones or to society*. **[35]**

The is nothing in the Bill to prevent people dying under its provisions due to social pressure of this kind, for example lack of access to adequate healthcare or social care. In this regard also the Bill may be subject to challenge under the ECHR.

**Review and judicial oversight**

The Bill as presented at Second Reading included a prior application to the High Court to determine eligibility before authorisation of provision of a lethal drug for the purpose of enabling a person to end their own life. **[36]** This court process was cited by many Parliamentarians as a key safeguard. **[37]** However, this provision was removed at Committee stage and replaced by a review panel including a lawyer, a psychiatrist and a social worker. **[38]** These would be appointed by a Voluntary Assisted Dying Commissioner. **[39]**

Whatever process of review is in place, it is essential that this process is fair and that the process itself respects human rights. The procedures in the Bill fail this test in at least two respects.

In the first place, in the case that a panel determines that the applicant is not eligible, and refuses to issue a certificate of eligibility, the applicant can apply to the VAD Commissioner for the determination to be reconsidered. **[40]** However, in the case where a certificate of eligibility is given, there is no provision for anyone else to apply for the determination to be reconsidered. This one-sided appeal process fails to protect the person's article 2 right to life because it permits an appeal that could lead to loss of life but not an appeal that could protect life. In so doing, it simultaneously breaches the person's article 6 right to fairness in judicial (or quasi-judicial) procedures.

The Government's response to this is that persons wanting to challenge the decision on the facts or on the procedure could appeal via judicial review. **[41]** However, this legal avenue is onerous and the provision of a statutory appeals procedure in one direction but not in the other direction is prejudicial to the protection of the right to life.

Related to this, the Bill does not make provision for anyone other than the applicant to apply to be a party to the case before the panel. It allows the panel to hear from and question 'any other person' **[42]**, but there is no mechanism on the face of the Bill to ask to be heard. Furthermore, even if a person is heard by the panel, they still lack the formal status of being 'a party to the

case'. **[43]** This makes it harder for family members or others close to the patient to show that they have standing to challenge the determination. It is an example of a wider problem in the Bill of the exclusion of family members from the process, which arguably engages with the person's article 8 right to respect for private and family life.

In regard to the fairness of the review process, and the bias against protection of life, the Bill may also be subject to challenge under the ECHR.

## Article 9 and Conscience Rights

The Bill is for Parliamentarians a matter of conscience **[44]**, and the implementation is a matter of conscience for professionals. The Bill when presented at Second Reading included a clause that was intended to protect professionals' article 9 rights to freedom of thought, conscience and religion. **[45]**

These provisions were weak in at least three respects. In the first place, while they offered protection to healthcare professionals they did not give protection to any other professionals who may be involved in the process, such as social workers or people working in care homes. The financial IA points out that prison officers may well be the first point of contact for prisoners who were seeking information about VAD services. **[46]** The Bill does not specify how the service will be delivered in practice but imposes on the Secretary of State the duty to institute regulations 'securing that arrangements are made for the provision of voluntary assisted dying services in England'. **[47]** The Government acknowledges that 'it is possible that such arrangements could require individuals to participate in the process'. **[48]**

A second problem with this clause was that it did not specify what was covered by 'participate' in the phrase 'participate in the provision of assistance in accordance with this Act'. **[49]** The danger is that this would be interpreted in a narrow way so that it only covered the roles and activities expressly set out in the Bill, for example acting as the 'coordinating doctor', but did not cover other forms of participation such as managing the assisted dying service or providing information on the service.

Indeed, the Bill expressly imposes on doctors a duty to 'ensure that the person is directed to where they can obtain information and have the preliminary discussion'. **[50]** The Government acknowledges that this duty to provide information amounts to a 'duty of referral', that it has no precedent in previous legislation, and that it 'could potentially engage a person's rights under article 9.' **[51]** The Government defends the restriction of the rights of conscience of doctors on the basis that 'the bill strikes a balanced and proportionate approach between the need to protect healthcare professionals' rights under article 9 (and article 14) against the need to protect the article 8 rights of a terminally ill person who is seeking assistance to end their own life'. **[52]** However, the ECtHR has declared that these article 8 rights are compatible with the current law in England and Wales, which prohibits all assistance in suicide. **[53]** This is because article 8 rights must be balanced against the duty to protect life (article 2). Indeed, it is remarkable that the Memorandum fails to acknowledge article 2 considerations in the context of discussing article 9. Once these are acknowledged, it becomes hard to argue that article 8 considerations are so strong that they can justify compelling doctors to participate in assisting suicide through the provision of information.

Finally, the Memorandum did not even raise the issue of the impact on institutions with particular religious ethos or identity. Freedom of thought

and religion includes freedom of association and freedom to express religious or conscientious beliefs through institutions such as churches, schools, care homes, hospitals or hospices. Provision for institutions such as hospitals or hospices not to have to participate would allow those professionals and patients who are opposed to assisted suicide to know that there are safe spaces where this would not be offered. It would permit institutions to have their own policies on whether or how far to participate, as an institution, as institutions have policies on other contentious matters, and to enforce these policies subject to existing employment law. The lack of accommodation for institutions could also threaten the very existence of a sector that is not only an expression of religious freedom but also attracts significant voluntary funding to services that are provided to the wider community.

At Report Stage an amendment was introduced with the intention of strengthening the conscience clause. **[54]** This amendment helpfully extends the right not to participate to any person (not only to healthcare professionals). However, while the amendment provides more examples of activities that are or are not obligatory, the ambiguity of the phrase 'participate in the provision of assistance' remains.

In relation to 'registered medical practitioners', the new amendment states that no one 'is under any duty to perform any function under or in connection with this Act' other than 'the giving of notifications' and 'recording of matters in a person's medical records.' **[55]** However, these exceptions are expanded by a later clause that allows doctors to be placed under an obligation to provide information and to respond to enquiries relating to health or social care the professional is providing, or has recently provided, to a person seeking assistance under this Act. **[56]** It turns out there a quite a number of things that a doctor might be required to do in connection with the Act and for other professionals the list may be still longer.

With regards to protection of institutions, an amendment which would have allowed for such protection was tabled at Report Stage. **[57]** However, this was opposed by Kim Leadbeater MP, sponsor of the Bill, and by Stephen Kinnock MP, speaking for the Government, on grounds of patient safety and workability. **[58]** Neither MP acknowledged that similar protection for organisations is in place in all ten jurisdictions in the United States with laws comparable to that proposed in the Bill. **[59]** In Oregon such institutional protections have been in place for over 25 years. No one who supports the Bill argues that the law in Oregon is 'unworkable'.

Without an amendment to protect institutions, clauses in the rest of the Bill would allow doctors to raise the issue proactively with patients, and to provide patients with lethal drugs, and be present with patients when they took these drugs, all within the walls of an institution which opposed these practices. Voluntary aided hospices, including those with a religious identity, would have no legal way to avoid becoming suicide clinics. Patients who found such practices threatening would have no safe haven where they could receive palliative care without the danger of being offered assistance in suicide.

The Bill, as amended at Report Stage, continues to offer only weak protection to the conscience of individual professionals and to offer no protection to religious institutions or to other institutions with their own distinct ethos. The practice would not be 'voluntary' in relation to these institutions. The Bill may thus be subject to challenge on the grounds that it breaches the article 9 right to freedom of thought, conscience and religion.

## Article 14 and Expansion of the Law

Human rights considerations, and especially article 14 that concerns discrimination, have the potential to widen eligibility criteria for the Bill. The current legal prohibition of assisted suicide in England and Wales is compatible with human rights as set out in the ECHR. There is no legal or human right to assisted suicide or euthanasia. However, if the law were changed to permit some form of assisted dying (whether assisted suicide or euthanasia) then the law must be applied fairly and without discrimination. Where comparable groups were treated differently, this difference would need clear justification.

The Bill covers patients who have a terminal illness whose death from that illness can reasonably be expected within 6 months. **[60]** This excludes people who have an incurable illness but who are not dying. More subtly, it also excludes people who have a disease from which they are expected to die, but is difficult to provide a prognosis of 6 months, or with a disease from which they are expected to die but are also at risk of losing mental capacity in the last 6 months of life. **[61]** If the Bill comes into force then it will face legal challenge by people who are not eligible and who consider this to be discriminatory.

In defence of the current form of the Bill, the Government states that if the eligibility criteria were expanded then there would be more scope for violations of the right to life. **[62]** This is clearly the case in the sense that anything that increases the number of deaths would increase the scope for violations. However, this does not necessarily justify reducing access by means which discriminate between different categories of people. Barriers to access should apply equally.

A second argument of the Government is that 'making assisted dying available more widely (such as exclusively on the basis of mental illness and / or disability) could implicitly devalue the lives of those who suffer from such conditions'. **[63]** This is a relevant consideration as people with mental illness and people with disability face discrimination and there is a legitimate concern that a change in the law should not have a negative impact on these groups. Indeed, it constitutes an important reason for maintaining the current legal prohibition on assisted suicide. On the other hand, if the Bill were implemented, assisted dying would be provided to some categories of people but not to others who arguably have the same level of suffering. This would certainly lead to legal challenge.

It should be noted that no jurisdiction in Europe with a form of assisted dying restricts eligibility to people with a terminal illness. All allow either assisted suicide for those without a terminal illness (as with Austria, Germany and Switzerland) or euthanasia for those without a terminal illness (as with Belgium, Luxembourg, the Netherlands and Spain). Hence the ECtHR has not yet considered a case where eligibility is limited to people with a terminal illness and whether this would be discriminatory. It cannot be ruled out that the law would be expanded.

Other jurisdictions outside Europe have seen expansion of assisted dying laws from those who death is 'reasonably foreseeable' **[64]** or who are in the 'terminal phase' **[65]** of illness, to those with conditions that are incurable but are not expected to cause death. If the Bill passed into law then attempts would certainly be made to use the courts to expand the eligibility criteria. This is something that Parliamentarians must consider when voting on this legislation. They should not assume that the provisions of the Bill would remain within their present limits but should assess the Bill on the assumption that it could well expand as a result of future legal challenge.

## Getting Help

If the issues discussed here affect you or someone close to you, you can call Samaritans on 116 123 (UK and ROI), visit their website https://www.samaritans.org/ or contact them on jo@samaritans.org.

If you are reporting or writing about a case of death by suicide, whether assisted or non-assisted, please consult media guidelines https://www.samaritans.org/about-samaritans/media-guidelines/ on how to do so responsibly.

# Endnotes

**Cover picture:** 'Courtroom of the European Court of Human Rights in Strasbourg', by Adrian Grycuk, Wikipedia (used under Creative Commons Attribution-Share Alike 3.0 Poland Licence).

**[1]** *Terminally Ill Adults (End of Life) Bill (as amended in the House of Commons Public Bill Committee): impact assessment* ('financial IA'), Department of Health and Social Care (DHSC) / Ministry of Justice (MoJ) (14 May 2025).

**[2]** *Terminally Ill Adults (End of Life) Bill: equality impact assessment* ('equality IA'), DHSC / MoJ (14 May 2025).

**[3]** *Terminally Ill Adults (End of Life) Bill: ECHR memorandum* ('Memorandum'), DHSC / MoJ (2 May 2025).

**[4]** The other two being: *Ending Life as Cutting Costs: Analysis of 'The Impact of the Terminally Ill Adults (End of Life) Bill I'*; and *An Equal Opportunity to Live: Analysis of 'The Impact of the Terminally Ill Adults (End of Life) Bill II'*.

**[5]** *Op. cit.*, Memorandum, p. 1.

**[6]** *Ibid.*, p. 10.

**[7]** *Pretty v United Kingdom* (2346/02).

**[8]** *Mortier v Belgium* (78017/17).

**[9]** *Op. cit.*, Memorandum, p. 10.

**[10]** For example, *R (Conway) v Secretary of State for Justice* [2018] EWCA Civ 1431 cited by the *Memorandum*, p. 10.

**[11]** For example, *R (Purdy) v DPP* [2009] UKHL 45, which required the DPP to produce an

offence-specific policy setting out the factors that will be taken into account in deciding whether to prosecute assistance in suicide.

**[12]** *Op. cit.*, Memorandum, p. 9.

**[13]** *Ibid*.

**[14]** Those focusing on the issue include submissions by Gillet (TIAB04), Paton (TIAB125), Kelly (TIAB176) Bow (TIAB185), and Ibbett (TIAB434). Other submissions that included interesting observations on this issue, some from personal experience, include Keene (TIAB46), House (TIAB55), the Royal College of Psychiatrists (TIAB67), the Pathfinders Neuromuscular Alliance (TIAB84), Denno (TIAB99), the Other Half (TIAB104), the Association for Palliative Medicine of Great Britain and Ireland (TIAB114), Herx et al. (TIAB130), Pembroke and Atkinson (TIAB137), Shaw (TIAB140), Ohlsen (TIAB143), Lyon (TIAB165), Wilson (TIAB231), Watt (TIAB263), Tan (TIAB241), Clark (TIAB245) (TIAB245(a)), Jeffrey, (TIAB254), Ibbett (TIAB270), Anon (TIAB274), Leeder (TIAB283)*[listed in index as TIAB285], Hopkins. (TIAB288), Granet (TIAB290), Reynolds (TIAB295), VISION consortium (TIAB304), Ashenfelter (TIAB306), Murray (TIAB308), Dempsey (TIAB323), Buckley (TIAB326), Trussell (TIAB353), Doerflinger (TIAB360), Thomas (TIAB368), Bien et al. (TIAB400), and Anon (TIAB433). The issue of preventing suicide was referred to in a further 67 submissions.

**[15]** *Ibid*., Written evidence submitted by Christine Kelly (TIAB176).

**[16]** Written evidence submitted by Steven Bow, FFPH, Consultant in Public Health (TIAB185).

**[17]** Transcript of the Public Bill Committee Debates on the Bill, col. 160.

**[18]** J. Herring, *The Right to be Protected from Committing Suicide*, Oxford: Hart Publishing, 2022, p. 135. Herring is open in principle to a change in the law in the area of assisted suicide or euthanasia, but considers that the topic should start with an acknowledgement of the right of all people to suicide prevention. On this see also B.L. Mishara and D.N. Weisstub 'Is Suicide Prevention an Absolute?' *Crisis*. 2018 Sep;39(5):313-317. doi: 10.1027/0227-5910/a000568. PMID: 30354747.

**[19]** Suicide Act 1961, s. 2(1) amended by the Coroners and Justice Act 2009, s. 59. The 1961 Act prohibited action by which a person 'aids, abets, counsels or procures' suicide. This was expanded in 2009 to 'encouraging or assisting' suicide, so as to cover statements posted on the internet that aim to encourage suicide.

**[20]** Mental Health Act 1983 (as amended 2007) s.56 and following, see also s.2 and following.

**[21]** For example the Australian MP, Alex Greenwich, transcript of the Public Bill Committee Debates on the Bill, col. 212. On the significance of this argument in the Australian debate, see D.A. Jones, 'Did the Voluntary Assisted Dying Act 2017 prevent "at least one suicide every week"?', *Journal of Ethics in Mental Health*, Open Volume 11: 1-20.

**[22]** *Op. cit.*, Financial IA, para. 88.

**[23]** *Ibid*.

**[24]** Güth, Uwe, *et al*. 'Conventional and assisted suicide in Switzerland: Insights into a divergent development based on cancer-associated self-initiated deaths.' *Cancer Medicine* 12.16 (2023): 17296-17307.

**[25]** Anne M. Doherty, Caitlyn J. Axe, and David A. Jones. 'Investigating the relationship between euthanasia and/or assisted suicide and rates of non-assisted suicide: systematic review', *BJPsych*

open 8.4 (2022). See also D.A. Jones, *Suicide Prevention: Does Legalising Assisted Suicide Make Things Better Or Worse?*, Oxford: Anscombe Bioethics Centre, 2022.

**[26]** S. Girma and D Paton, 'Is assisted suicide a substitute for unassisted suicide?', *European Economic Review* (2022) 145: 104113; D. Paton and S. Girma, 'Assisted suicide laws increase suicide rates, especially among women', *Vox EU*, 29 Apr 2022.

**[27]** *Op. cit.*, Memorandum, p. 16.

**[28]** *Ibid.*

**[29]** *Ibid.*, p. 17.

**[30]** *Ibid.*

**[31]** Department for Constitutional Affairs, *Mental Capacity Act 2005: Code of Practice*, London: TSO, 2007, chapter 13.

**[32]** Mental Health Act 1983 (as amended 2007) s.2 and following. For discussion of the insufficiency of the Mental Capacity Act in this context, and a defence of the continuing validity of the approach in the Mental Health Act, at least in broad terms, see *op. cit.*, Herring, *The Right to be Protected from Committing Suicide*, chapter 7.

**[33]** *Op. cit.*, Memorandum, p. 17.

**[34]** Written evidence submitted by the Royal College of Psychiatrists (TIAB67), paras 9–11. See also *Press release: RCPsych comments on vote for assisted dying Bill in England and Wales* (29 November 2024); *Press release: The RCPsych cannot support the Terminally Ill Adults (End of Life) Bill for England and Wales in its current form* (13 May 2025).

**[35]** *RCP position statement on the Terminally Ill Adults (End of Life) Bill* (9 May 2025).

**[36]** *Op. cit.*, Memorandum, p. 17; quoting section 3 of the Euthanasia Act of 28 May 2002 as quoted in *Mortier v Belgium* at 50.

**[37]** *Ibid.*

**[38]** Written evidence submitted by The Equality and Human Rights Commission (ADY0317) to the House of Commons Health and Social Care Committee on Assisted Dying / Assisted Suicide (January 2023).

**[39]** Terminally Ill Adults (End of Life) Bill (as amended in Public Bill Committee), clause 12.

**[40]** Hansard, Terminally Ill Adults (End of Life) Bill Second Reading Debate (29 November 2024) Volume 757. See contributions by Kim Leadbeater (cols. 1012, 1019), Alicia Kearns (col. 1012), Andy Slaughter (col. 1033), Lizzi Collinge (col. 1065), Simon Opher (col. 1070), and Peter Bedford (col. 1074).

**[41]** *Op. cit.*, Terminally Ill Adults (End of Life) Bill, clause 15, Schedule 2.

**[42]** *Ibid.*, clause 4, Schedule 1.

**[43]** *Ibid.*, clause 16.

**[44]** *Op. cit.*, Memorandum, p. 19.

**[45]** *Op. cit.*, Terminally Ill Adults (End of Life) Bill, clause 15(4)(d).

**[46]** *Op. cit.*, Memorandum, p. 24.

**[47]** Alex Davies-Jones MP, 'The Government are of the view that any change to the law in this area is an issue of conscience for individual parliamentarians' speaking as Parliamentary Under-Secretary of State for Justice. Hansard, Terminally Ill Adults (End of Life) Bill Second Reading Debate (29 November 2024) Vol. 757, col. 1082.

**[48]** *Op. cit.*, Terminally Ill Adults (End of Life) Bill, clause 23, though note that it does not use the term 'conscience' or 'conscientious objection'.

**[49]** *Op. cit.*, Financial IA, para. 106, with acknowledgement to Miriam Green, Policy and Research Analyst at CBCEW for drawing this to my attention.

**[50]** *Op. cit.*, Terminally Ill Adults (End of Life) Bill, clause 38(1).

**[51]** *Op. cit.*, Memorandum, p. 32.

**[52]** *Op. cit.*, Terminally Ill Adults (End of Life) Bill, clause 28(1) (identical to 23(1) in the Bill as introduced).

**[53]** *Ibid.*, clause 28(1 (clause 5(6).

**[54]** *Op. cit.*, Memorandum, p. 31.

**[55]** *Ibid*.

**[56]** *Pretty v United Kingdom* (2346/02).

**[57]** NC 10, see Amendment Paper 16 May 2025, Report Stage.

**[58]** *Ibid.*, Report Stage, clause (3).

**[59]** *Ibid.*, Report Stage, clause (7).

**[60]** NC 10(a), tabled by Rebecca Paul MP., see Amendment Paper 16 May 2025, Report Stage.

**[61]** Hansard, Terminally Ill Adults (End of Life) Bill Report stage Debate (16 May 2025), Volume 767, See Kim Leadbeater (col, 633) and Stephen Kinnock (col, 703).

**[62]** Oregon 1997: Death with Dignity Act. 127.885 §4.01. (4) and (5); Washington 2009, Death with Dignity Act. RCW 70.245.190 (1)d, (2); Vermont 2013 Act 39 Patient Choice and Control End of Life Act, § 5286. Colorado 2015, End of Life Options Act, 25-48-118; California 2015, End of Life Option Act. 443.15; District of Columbia Law 21-182 Death with Dignity Act, Section 11 c and d; Hawaii 2019. Our Care, Our Choice Act, §327L-19 b and c; New Jersey 2019. Medical Aid in Dying for the Terminally Ill Act, 26b 2; Maine 2019, Death with Dignity Act, § 2140. 22 B and C; New Mexico 2021. Elizabeth Whitefield End-of-Life Options Act, Section 7.

**[63]** *Op. cit.*, Terminally Ill Adults (End of Life) Bill, clause 2(1).

**[64]** This was a key argument in persuading politicians in Victoria, Australia, to extend the provision from expectation of death within 6 months to 12 months for people with neurodegenerative conditions. However, it is doubtful how much difference this makes in practice, as the proportion of people with such diseases who die by assisting suicide / assisted dying was smaller in Victoria than in Oregon (which makes no exception to the 6 month rule for these diseases). See *op. cit.*, D.A. Jones, *Ending Life as Cutting Costs: The Impact of the Terminally Ill Adults (End of Life) Bill I,* Oxford: Anscombe Bioethics Centre, 2025, footnote 14.

**[65]** *Op. cit.*, Memorandum, p. 28.

**[66]** *Ibid.*, pp. 28, 35.

**[67]** As was the law in Canada from 2016 to 2021 – see Government of Canada: Canada's medical assistance in dying (MAiD) law.

**[68]** As was the law in Colombia from 2015 to 2021 – see Columbia Ministry of Health 2015 Resolution 1216, article 2: '*Enfermo en fase terminal.*'; O. Dyer, 'Colombia allows euthanasia of two people with non-terminal illness', *BMJ* 2022; 376 :o67 doi:10.1136/bmj.o67.

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