UNIVERSITY OF Southampton

Assisted Suicide Policy Team
Crown Prosecution Service Headquarters
50 Ludgate Hill
London
EC4M 7EX

14 December 2009

Dear Sirs,

Re: HEAL Response to Consultation on Interim Policy for Prosecutors in respect of cases of assisted suicide

This response is the product of discussion by members of HEAL UoS (Health, Ethics And Law, University of Southampton). This is an interdisciplinary group of academics and clinicians who are associated with the University of Southampton. It is not a formal response from the University as an institution, but reflects the views of members of the network. A significant number of concerns were raised about the detail of the document which rendered it impossible to respond within the tick box format provided in the consultation. Also, as one might expect, not every individual is of the same view. Consequently the group felt it pertinent to feedback its concerns in the form of this letter.

General concerns

The group were worried about the terminology used throughout, specifically the use of 'victim' and 'suspect'. Whilst we understand the reasons for selecting this language to be related to the fact that potential criminal offences are involved these words generate specific value-laden judgements. More particularly, there is a concern that naming the assisted person as a victim implies that the suicide was not their choice and this is inappropriate in the kinds of circumstances the guidance is apparently designed to govern.

Factors in favour of prosecution

Qu 1: The consensus view was that the issue of age is irrelevant since the main concern should be with the ability of the assisted person to exercise their individual autonomy; this is not age dependent.

Qu 2: The group was unanimous in responding YES to this question.

Qu 3. The group felt that there are distinctions to be drawn between 'clear' 'settled' and 'informed' and were concerned that this was simply an extension of testing the person's capacity. Furthermore, it was unclear which, if any, of these would carry more weight in practice.

Qu 4. Raised evidential concerns as to how these factors would be demonstrated or proved.

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Qu 5. Initiative was thought to be a factor, but perhaps not decisive, whereas coercion would be more significant in deciding whether or not to prosecute.

Qu 6. The group answered no to this question. It was felt that these factors were not specifically relevant and were also too wide in scope. In addition the terms used appear to imply that some lives are inherently more valuable than others.

Concerns were also raised as to whether this pointed to an underlying policy that suicide is somehow inherently 'bad' and therefore to be discouraged. An alternative understanding of the point is that suicide is an action that people are free to choose, and that being so those who are not physically able to commit suicide should be assisted to do so.

Qu 7. Raises concerns about what is meant by 'compassion', i.e. how is it defined? The wording 'wholly motivated' is also problematic. How can this be demonstrated/evidenced?

Qu 8. Refers to two separate and distinct things, i.e. actions and omissions. What is meant by 'improper' influence? The terminology suggests that some influences (interventions) may be regarded as proper?

Also, what are reasonable steps to take? Potentially this seems to be moving towards imposing a duty to prevent suicide.

Qu 9. This is not a black/white issue capable of a yes/no answer, the factors to be considered under this heading need to be more subtle and nuanced.

Qu 10. Appears to reverse the general presumption that persons will be most protected by those who they trust or who care for them.

Qus 10-13. Appear to be concerned with preventing the development of a euthanasia industry but are imprecise, especially in the context of *A-G v Able*. Specifically, Qu 12., why is it worse to be involved in more than one suicide? Furthermore, it was felt that these are matters for the legislature.

Qu 13. How does this differ from the earlier point about undue influence or pressure?

In addition, concerns were raised about the use of the evidence of 'assistance' in Qu 12.

Qu 14. This is problematic for those involved in hospice care and nursing home environments. It was suggested by some members of the group that people will sometimes want to discuss end of life options, including suicide, and that they [hospice/care workers] may be implicated as assistors if those patients subsequently decide to kill themselves. This might result in counselling in hospice situations becoming onerous for staff and unhelpful to patients.

Qu 15. The rationale behind this question is difficult to comprehend.

Qu 16. Seems to be only loosely connected with the other concerns but seems to be aimed at preventing routinisation/normalisation of assisted dying.

Factors against prosecution

Qu 7. There is a need to define the offence more clearly and consider possible evidence. See previous concerns raised about hospice carers.

Qu 9. There is an evidential problem with this question. How can a person demonstrate that they tried to persuade the assisted person? Does this raise a criminal duty to prevent suicide?

Qus 10-13. Seem to be (inappropriately?) informed by a policy/view that suicide is 'bad' and should therefore always be a last resort. In addition there appear to be contradictory messages within this series of questions. For instance, assistors may be reluctant in their actions but prepared to fully assist the police, or *vice versa*.

Yours faithfully,

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