

Assisted Suicide: OSAB Safeguarding Briefing for Practitioners



At the time of writing (Summer 2024), all forms of assisted dying are illegal in all parts of the UK. A decision about whether to prosecute someone is taken on a case-by-case basis by the Crown Prosecution Service (CPS) in England and Wales; the Public Prosecution Service (PPS) in Northern Ireland; and the Crown Office and Procurator Fiscal Service (COPFS) in Scotland.

What is considered 'assisting suicide'?

A person commits an offence under [section 2 of the Suicide Act 1961](#) if they do an act capable of encouraging or assisting the suicide or attempted suicide of another person, and that act was intended to encourage or assist suicide or an attempt at suicide.



This can include:

- advising people about what constitutes a fatal or planned dose.
- interference with any medical interventions that may bring about the person's death.
- suggesting the option of suicide abroad.
- writing any reports specifically to facilitate assisted suicide abroad.
- providing literature on aspects of assisted suicide.
- disseminating information via the media (including the internet) which would be likely to encourage people to end their lives.
- putting people in touch with other individuals or groups who may be able to assist or organisations who promote assisted dying.
- facilitating any other aspects of planning a suicide.

Practitioners who are unsure about how a particular action might be viewed in law should seek up to date legal advice.

What if a Person Wishes to Travel Abroad for Assisted Dying?

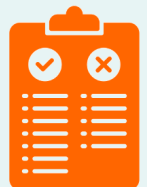


While the act of travelling abroad to receive assisted suicide is not illegal, assisting, facilitating or encouraging someone to do so is a criminal offence.

Although to date there has been no prosecution for people accompanying others abroad to end their lives, practitioners need to be aware of the possibility of legal and professional sanctions if they were to do so. This applies both to accompanying a person abroad to receive assisted dying in a professional capacity, or in a personal capacity with a friend or family member. The prosecutorial authorities will consider the same factors for both in deciding to prosecute. When faced with a request from a person for assisted dying, practitioners must respond professionally and compassionately, and continue to support them with their ongoing care and treatment.

How Should Practitioners Respond?

The British Medical Association (2023) recommend practitioners working with people who are actively seeking assisted suicide should respond sensitively, compassionately, and non-judgmentally. At the same time, they must ensure that their response does not contravene the law by encouraging or assisting suicide.



Practitioners may find the following points to be helpful:

- Practitioners should listen to the person and acknowledge the request: it is important that practitioners listen to what the person is telling them; and respond honestly to their questions.
- Practitioners should not ignore or brush past what the person wishes to talk to them about. These conversations can be in-depth, and it is important that practitioners allocate sufficient time in which to have them.
- Practitioners should be clear about the law, explain the legal situation in the UK, and that there could be serious consequences for the practitioner or anyone else who might assist the person in ending their life.
- Practitioners should explore the range of other interventions available to them, within the law, which might be able to help.

- Practitioners should be clear that they cannot do or say anything that might be interpreted as assisting the person to end their life.
- Practitioners should provide objective advice about the lawful clinical options available: they can and should discuss treatment options with people including the option of no treatment and Advanced Decisions to Refuse Treatment (ADRTs). *
- Practitioners should work with General Practice (GP) to provide objective advice about the lawful clinical options available to the person at the end of life (including pain relief and symptom control).



- Practitioners should create opportunities for the person to express their fears and concerns and explore how those might be addressed.

- Practitioners should explore the person's feelings, emotions and thoughts: the expression of a desire or wish to die can indicate that there are underlying physical, practical, or emotional issues that need to be explored.
- It might be helpful to discuss the person's understanding of their condition or their fears and concerns, or those of people close to them. If practitioners believe that the person is depressed or suffering from another mental health condition, or would benefit from more support, therapy or counselling should be offered.
- Practitioners should address the person's concerns: investigate whether other practical arrangements could help improve their quality of life. It is also an opportunity to review the person's current care and treatment; to explore whether there are other options for investigations, treatment or management that might help them; or to revisit advance care planning and the recording of their future wishes in the event that they might lose mental capacity.
- Practitioners should be non-judgmental and non-partisan: it is important that practitioners continue to maintain a professional relationship with the person and make them aware that they can continue to speak to them and express their feelings.
 - Whatever the practitioner's personal views are, it would be inappropriate to discuss these with the person or to let them influence the care and treatment provided.
 - Practitioners should not abandon the person: in some cases, it may be that there is not an underlying problem or

concern that can be identified and remedied, and the person continues to feel as though assisted dying is the only option for them. These circumstances can be particularly challenging but, even though practitioners are unable to meet their request, they must not abandon the person. It is important that practitioners continue to acknowledge and address concerns, provide assurances about the care they can provide, and continue to support the person.

How can Professional Support be Accessed?

Any cases arising concerning assisted suicide may evoke personal and professional values, sometimes conflicted by personal experiences. Practitioners should identify who in their organisation or agency they could talk to for advice, guidance, and support to both assist their response to the person, and from a staff wellbeing perspective:



- Practitioners' line managers or agency safeguarding leads may be the first source of support for this.
- Involve a colleague: practitioners might want to involve a more experienced colleague whilst making this clear to the person that this is what they will be doing.
- Involve other sources of support: utilise the [Tiered Risk Assessment and Management \(TRAM\) Protocol](#) to seek support and input from members of the healthcare team, such as a specialist palliative care team, colleagues from mental health, chaplaincy or voluntary services.

* Advance decisions to refuse treatment (ADRT): a valid and applicable advance decision to refuse treatment must be respected. Competent, contemporaneous refusals of care and treatment: an informed refusal by a competent adult must be respected, even if it will result in serious injury or death. This includes a competent refusal of food and fluids. In these cases, it would be appropriate to discuss with the person in advance what pain and symptom relief will be available at such a point in time that it becomes necessary.

References

- British Medical Association (2023) Responding to patients requests for assisted dying: guidance for doctors. Accessed online 10 June 2024. Accessed from: [bma-guidance-on-responding-to-patient-requests-for-assisted-dying-for-doctors.pdf](#).
- UK Public General Acts (2011) Suicide Act 1961, Section 2. Accessed online 10 June 2024. Accessed from: [Suicide Act 1961 \(legislation.gov.uk\)](#).

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