PUBLIC PROSECUTION SERVICE

Public Prosecution Service for Northern Ireland

Summary of Responses to PPS Interim Guidance on the Offence of Assisted Suicide

Independent, Fair and Effective

CONTENTS

Introduction

Responses to the consultation document were received from those individuals and organisations listed in Annex A. Furthermore the issue of the interim guidance was the subject of a debate in the Northern Ireland Assembly on the motion,

That this Assembly notes the verdict in the Purdy case and the decision by the Director of Public Prosecutions in Northern Ireland to issue guidance on assisted suicide; and states its opposition to any attempt to legalise assisted suicide.

Details of those who took part in the debate are included in Annex A and the full text of the debate is included at Annex B.

Some respondents chose to follow the questions posed in the consultation document while others preferred to provide comment by way of narrative. Some respondents felt that the format of the consultation questions was inappropriate given the complexity of the issues concerned, while others felt that the questions were confusing.

Responses to the specific questions posed in the consultation document are set out in the table below. This includes general comments made in response to Question 9. It has been possible to identify a number of recurring themes in the responses received, namely:-

1. There is more widespread agreement with the factors identified in favour of prosecution than those identified as factors against prosecution.

2. There is concern that the broad presumption that the public interest requires prosecution where there has been a contravention of the criminal law set out in paragraph 4.3.3 of the Code for Prosecutors has not been reiterated in the interim guidance. One respondent described this as a shift in the role of the PPS from one of enforcing the law other than in exceptional circumstances to one of arbitrating, in an even handed manner, between the merits and demerits of prosecuting those who assist suicides.

3. There is a particular concern that there should be greater clarity around the impact of the guidance on health professionals.

Question 1: Public Interest Factors in favour of prosecution

Number	Factor in favour of prosecution	Comment
(1)	The victim was under 18 years of age	There was general support for this factor.
(2)	The victim's capacity to reach an informed decision was adversely affected by a recognised mental illness or learning difficulty.	It was suggested that this could be broadened to include physical illness such as a stroke. It was further felt that there might be difficulty in defining what is meant by a recognised mental illness. There was broad support for the factor being based upon the victim's capacity.
(3)	The victim did not have a clear, settled and informed wish to commit suicide; for example, the victim's history suggests that his or her wish to commit suicide was temporary or subject to change.	There was some opposition to this factor on the basis that it would be difficult to establish and that it was based on the assumption that the existence of a clear, settled and informed wish was consistent with rational thought and precluded the possibility of mental illness.
(4)	The victim did not indicate unequivocally to the suspect that he or she wished to commit suicide	Generally supported.
(5)	The victim did not ask personally on his or her own initiative for the assistance of the suspect.	It was felt this lacked clarity.
(6)	The victim did not have: • a terminal illness; or • a severe and incurable physical disability; or • a severe degenerative physical condition; From which there was no possibility of recovery.	There was some opposition to this factor on the ground that it suggested a pejorative view of disabled people.
(7)	The suspect was not wholly motivated by compassion; for example, the suspect was motivated by the prospect that they or a person closely	It was suggested that there might be further clarification by specifying that the gain might be financial or otherwise, for example relief from caring responsibilities. A particular concern expressed was whether this factor

Number	Factor in favour of prosecution	Comment
	connected to them stood to gain in some way from the death of the victim.	might be engaged by the provision of medical records by a doctor upon request by a patient.
(8)	The suspect persuaded, pressurised or maliciously encouraged the victim to commit suicide, or exercised improper influence on the victim's decision to do so; and did not take reasonable steps to ensure that any other person did not do so.	It was suggested that the words maliciously and improper might be deleted from this factor.
(9)	The victim was physically unable to undertake the act that constituted the assistance him or herself.	It was suggested that there might be some clarification on what is meant by "the act".
(10)	The suspect was not the spouse, partner or a close relative or a close personal friend of the victim.	Some concern was expressed that there should not be special category status for those identified and that to do so is based on a naïve assumption of the nature of family relationships. A further comment was that the list of excluded relationships should include that of doctor/patient.
(11)	The suspect was unknown to the victim and assisted by providing specific information via, for example, a website or publication, to the victim to assist him or her in committing suicide.	There was widespread support for this factor.
(12)	The suspect gave assistance to more than one victim who were not known to each other.	Some respondents felt that the requirement for victims to be unknown to each other should be deleted.
(13)	The suspect was paid by the victim or those close to the victim for their assistance.	It was suggested that this should be confined to actual gain and not reimbursement of travel expenses for example. Concern was further expressed as to whether this factor engaged the provision by doctors of medical records for payment.
(14)	The suspect was paid to care for the victim in a care/nursing home environment.	A number of respondents felt that this factor should be broadened to include other paid carers.

Number	Factor in favour of prosecution	Comment
(15)	The suspect was aware that the victim intended to commit suicide in a public place where it was reasonable to think that members of the public may be present.	This was generally approved.
(16)	The suspect was a member of an organisation or group, the principal purpose of which is to provide a physical environment (whether for payment or not) in which to allow another to commit suicide.	There was general approval for this factor. Some respondents suggested that it should be broadened to include clients as well as members of an organisation and that the factor should be broadened by replacing the word principal with the word one and adding at the end of the description the words “or information or resources”.

QUESTION 2

The following additional factors in favour of prosecution were proposed:-

- The suspect was a physician, surgeon, nurse or other healthcare professional and the victim was under his or her care.
- The suspect or victim was not resident in the UK or a UK citizen.
- The suspect had a history of violence or abuse towards the victim.

QUESTION 3

Respondents were generally in favour of the factors identified as carrying more weight than others. The only factors which respondents disagreed with being included were numbers 3 and 6.

QUESTION 4

Respondents considered that factors 9, 11, 12, 14 and 16 and that the proposed additional factors of the suspect being a healthcare professional and there being a history of violence or abuse towards the victim should carry additional weight.

Question 5: Public Interest Factors against prosecution

Number	Factor in favour of prosecution	Comment
(1)	The victim had a clear, settled and informed wish to commit suicide.	There was considerable opposition to this factor. Where reasons were given this appeared to be based upon the difficulty of establishing that a clear, settled and informed wish existed; the difficulty of what is meant by this in the context of someone in distress and that this presupposes rational thought to the exclusion of possible mental illness.
(2)	The victim indicated unequivocally to the suspect that he or she wished to commit suicide.	There were similar levels of concern as those expressed for factor 1.
(3)	The victim asked personally on his or her own initiative for the assistance of the suspect.	There were similar levels of concern as those expressed for factor 1.
(4)	The victim had: • a terminal illness; or • a severe and incurable physical disability; or • a severe degenerative physical condition; From which there was no possibility of recovery.	There was considerable opposition to this factor. Where reasons were given these were largely that the inclusion of this factor provided a lesser degree of protection to those in society who are more vulnerable and hence was discriminatory.
(5)	The suspect was wholly motivated by compassion.	This factor was generally approved. A number of respondents suggested that it could be replaced with *"the suspect did not stand to gain"*.
(6)	The suspect was the spouse, partner or a close relative or a close personal friend of the victim, within the context of a long-term and supportive relationship.	There was considerable opposition to this factor. Where reasons were given these were largely that the factor was based on assumptions about the nature of family and close relationships which may not necessarily be true in the individual case.
(7)	The actions of the suspect, although sufficient to come within the definition of the offence, were of only minor	This factor was generally accepted. It was suggested that it might be confined to apply only where the actions took place after a settled intention to commit suicide had been

Number	Factor in favour of prosecution	Comment
	assistance or influence, or the assistance which the suspect provided was as a consequence of their usual lawful employment.	formed. Some respondents considered that concrete examples would help clarify what is meant by the factor. A number of respondents further considered that it should be made explicit that doctors and other healthcare professionals were not included.
(8)	The victim was physically unable to undertake the act that constituted the assistance him or herself.	A considerable number of respondents opposed this factor. Where reasons were given these were largely to the effect that this factor reduced the protection available for the disabled and hence was discriminatory.
(9)	The suspect had sought to dissuade the victim from taking the course of action which resulted in their suicide.	There was some opposition to this factor on the basis that it might be difficult to establish.
(10)	The victim has considered and pursued to a reasonable extent recognised treatment and care options.	There was some opposition to this factor on the basis that it was discriminatory.
(11)	The victim had previously attempted to commit suicide and was likely to try to do so again.	There was considerable opposition to this factor. Respondents were concerned that this factor might encourage attempts and that the factor was objectionable for the reasons set out for factors 1 to 4.
(12)	The actions of the suspect may be characterised as reluctant assistance in the face of a determined wish on the part of the victim to commit suicide.	There was general acceptance of this factor.
(13)	The suspect fully assisted the police in their enquiries into the circumstances of the suicide or the attempt and his or her part in providing assistance.	There was general support for this factor.

QUESTION 6

Respondents suggested the following additional factors against prosecution:-

- if the victim has sought to provide evidence of factors against prosecution
- the suspect did not stand to gain any advantage from the death.

QUESTION 7

Respondents were generally in favour of the selection of factors against prosecution which should carry more weight than others. There was particular support for factors 5 and 7 in this context.

QUESTION 8

There was some support for factors 9 and 12 to be included among those factors carrying more weight than others in deciding that a prosecution is not required in the public interest.

QUESTION 9

The following general comments were made:-

- The interim guidance is a precursor to changing the law to permit assisted suicide and should be opposed on that basis.
- The existing prohibition on assisted suicide should not be lifted.
- The interim guidance is inconsistent with other offence specific policies insofar as it does not appear to be based upon a presumption in favour of prosecution and displays an improper attitude to victims.
- The guidance should state that solicitors must not give advice which would facilitate assisted suicide.
- Factors against prosecution are mitigating factors only. There should always be a prosecution (evidence permitting) and such factors taken into account by the sentencing court.
- There is an unresolved tension between factor 13 in favour of prosecution and factor 7 against.
- There is no reference to the means of commission of the act of suicide. Consideration might be given to including this as a factor in favour of prosecution.

- The publication of the guidance is indicative of acceptance of a moral recklessness with the capacity to harm others for example the acceptance of suicide bombing as a legitimate form of political protest.
- It is likely to be difficult to measure the gain achieved by an individual through the death.
- The interim guidance discriminates against the disabled.
- The interim guidance should not refer to the victim but to person P.
- It would be preferable to use the term "*have an assisted death*" in place of "*commit suicide*".
- The final guidance should reference new legislation on mental capacity.
- There is no *"right to die"*. Life is a gift from God.
- The guidance must include a clear statement that assisted suicide is and remains a criminal offence.

PPS Response to Public Consultation

The PPS welcomes the responses which have been received both from individuals and on behalf of organisations. On some issues responses have been received which advocate both sides of the argument; on others there has been broad consensus. In considering what changes should be made to the interim guidance the Director has given careful consideration to all the views that have been expressed.

The following changes to the interim guidance have been made and will apply from 25th February 2010:

1. A new introduction provides the context in which the guidance is issued and re-states the important principle that it is only Parliament who can change the law on assisted suicide.

2. The changes which have been made to the description of the offence of assisted suicide by the Coroners and Justice Act 2009 have been worked into the text.

3. The description of the Evidential Test has been expanded to provide greater clarity on the distinction between acts of encouragement or assistance which may amount to the offence of assisted suicide and acts which end the life of another which may amount to murder or manslaughter.

4. The description of the Public Interest Test has been expanded so as to provide more detail of how this part of the Test for Prosecution is applied. In particular there is now set out the broad presumption that the public interest requires prosecution where there has been a contravention of the criminal law.

5. There was widespread support for most of the public interest factors identified in favour of prosecution, subject to clarification and amendment in some instances. In particular factor number 14 has been redrafted to include specific reference to medical doctors, nurses and other healthcare professionals. The following public interest factors did not receive the same degree of support and have been removed from the final guidance:

(i) The victim did not have:

- a terminal illness; or
- a severe and incurable physical disability; or
- a severe degenerative physical condition;

from which there was no possibility of recovery.

(ii) The suspect was not the spouse, partner or a close relative or a close personal friend of the victim.

The following additional public interest factor in favour of prosecution was identified by the consultation and has been included:

The suspect had a history of violence or abuse against the victim.

6. There was less support generally for those public interest factors identified in the interim guidance against prosecution. In some instances there was strong opposition expressed to particular factors. Having regard to the views expressed a number of public interest factors against prosecution have been removed. The factors which have been retained focus on the suspect rather than the victim, with the exception of number (1), that the victim had reached a voluntary, clear, settled and informed decision to commit suicide. No additional factors against prosecution were identified.

7. The weighting of the public interest factors against prosecution no longer serves a useful purpose as these factors have now been significantly reduced in number. This being so, it is considered that in the interests of consistency those factors in favour of prosecution should likewise no longer be weighted.

8. The Director has given careful consideration to the general views expressed in the drafting of the final guidance.

ANNEX A

List of Respondents

Care Not Killing Alliance
Medical Defence Union
Acting Assistant Chief Constable Nigel Grimshaw
Mrs Stella Wilson
Probation Board for Northern Ireland
British Medical Association
Society for the Protection of Unborn Children
Presbyterian Board of Social Witness
Northern Ireland Human Rights Commission
Disability Action
DHSSPS Nursing and Midwifery Directorate
Northern Ireland Association of Social Workers
Samaritans
CARE
The Alzheimer's Society
Nicola O'Neill
General Medical Council
Assistant Chief Constable Andrew Harris
Christian Renewal Centre
Catherine McBennett
Northern Ireland Court Service
Dr John Jenkins
Dr James Nelson
Jan Hayward
The Superintendents Association of Northern Ireland
Margaret Butler
Peter Gray
Nicolas McAtamney

The following persons with addresses in NI responded to the CPS consultation and their responses have been shared by the CPS with the PPS.

Dr Cathal Steele
Dr Werner McIlwaine
Mr Tommy McLaughlin
Mr David Silversides
Mr Andrew McKelvey
Mrs Claire Masih
Miss Ashleigh Martin
Mr Hugh Marcus
Dr Carolyn Hunter
Mr Mervyn Hawe
Mr William Wallace
Dr Jonathan Silversides
Dr Peter O'Halloran
Mrs Lorien Megaw
Dr Ronald Atkinson
Siobhan Sweeney
Dermot McAtamney

List of Speakers in Northern Ireland Assembly Debate

Mr Donaldson
Ms Anderson
Mr Kennedy
Mrs Hanna
Mr Ford
Mrs I Robinson
Mr O'Dowd
Mr Wells
Mr Kinahan
Mr A Maginness
Mr McNarry
Ms S Ramsey
Mr Easton
Lord Morrow
Mr Attwood
Mr Shannon
Mr Hamilton

ANNEX B
Official Report of Debate in the Northern Ireland Assembly on 12th October 2009

Private Members' Business

Assisted Suicide

Mr Speaker: The Business Committee has agreed to allow up to one hour and 30 minutes for the debate. The proposer will have 10 minutes to propose the motion and 10 minutes in which to make a winding-up speech. All other Members who speak will have five minutes.

Mr Donaldson: I beg to move

That this Assembly notes the verdict in the Purdy case and the decision by the Director of Public Prosecutions in Northern Ireland to issue guidance on assisted suicide; and states its opposition to any attempt to legalise assisted suicide.

I welcome the opportunity to propose the motion in the names of myself and my honourable friends the Member for Strangford Mr Hamilton and the Member for South Down Mr Wells.

The background to the issue of assisted suicide or euthanasia, if you prefer, is based on the recent developments that occurred in the House of Lords, where a case was brought by a lady called Debbie Purdy, who sought clarification on the circumstances in which prosecutions might be brought in cases that involve assisted suicide. As a result of the observations that were made by the Law Lords in that case, it was necessary for the Public Prosecution Service (PPS) here and the Crown Prosecution Service (CPS) in England and Wales to publish interim guidance for the courts or anyone else on the circumstances in which prosecutions might be brought in cases of assisted suicide. The Director of Public Prosecutions in Northern Ireland issued his interim guidance on 23 September and launched a consultation process on the subject.

It is timely that we are discussing the issue. It is a matter that affects people in Northern Ireland, it is a matter of national import, and it is the cause of debate across the United Kingdom. It is a cause for concern. We made clear in the text of the motion that we are unequivocally opposed to the legalisation of assisted suicide or euthanasia in the United Kingdom.

Christianity teaches us that human life — all human life — is valuable and that the deliberate taking of life is wrong. That is the starting point for my examination of the issue. Human life is valuable and ought to be valued, not just the young, people who we regard as productive or the able-bodied in our society but all human life.

(Mr Deputy Speaker [Mr Dallat] in the Chair)

I happen to have the privilege of having a younger brother. He was born with cerebral palsy. Andrew has lived all his life in circumstances in which he has had a very limited form of life experience. He finds it difficult to communicate and he cannot walk, and I pay tribute to my mother and father for their dedication over the years in caring for him.

Let me be clear that there are no circumstances in which my family would consider it appropriate to take steps to end Andrew's life prematurely. We believe that his life is in the hands of God and not in our hands. We believe that the duration of his life is in the hands of God and not in our hands. Doctors told us that Andrew would not live for very long after he was born. However, more than 40 years later, he is still alive and still making his presence felt in our family home in the kingdom of Mourne.

Baroness Warnock, a leading member of the House of Lords, said that people with dementia, another medical condition that is often associated with assisted suicide, waste people's lives and the resources of the National Health Service. In her view, people with dementia are a drain on the resources of the National Health Service, and their lives are wasting away. She believes, therefore, that they almost have a duty to die. That attitude, which devalues human life to the extent that people are regarded as a drain on the resources of our Health Service and have some kind of duty to die, is appalling. It is contrary to the values and standards that I hope the Assembly would uphold in preserving and protecting the right to life in every circumstance.

Such an attitude wrongly evaluates people in terms of their benefit to others or what society can gain from their existence. It denies them their intrinsic value as human beings made in the image of God. A decision that the intentional ending of human life can be not only acceptable but therapeutic and a legitimate means of relieving pain and distress is a monumental step for our society to take. If human life can be terminated when it becomes too difficult and if some people are considered better off dead, how will society determine which lives are proper candidates for termination and which are not? How will we prevent the principle that certain lives can be terminated becoming a rule that they should be terminated?

Acute human suffering should not be dealt with by disposing of the person facing that suffering. We all recognise that there is acute human suffering. We all recognise what individuals and families have to go through when the health of a loved one deteriorates or when someone has a lifelong condition that limits his or her well-being and enjoyment of life. However, I do not believe that the answer is the legalisation of suicide, assisted suicide or the premature termination of life.

The pro-euthanasia lobby features a vocal minority of independently minded and articulate patients who want to control the time and manner of their death. However, the vast majority of those seeking to access legally assisted suicide do not fit into that

category. Rather, they are the most vulnerable members of society: elderly people; terminally ill people; incapacitated people; and depressed people. Those people often feel uncertain about whether their lives are worth living and fear becoming a burden to others. We all have experience of older people who wrongly regard themselves as a being a burden on others. If assisted suicide were legal, many would feel that they had a duty to request an early death, especially if it were offered by their physician as a possible therapeutic option. Some people would face the added risk of coercion by others who might stand to gain financially or otherwise from their death.

Medical professionals are opposed to euthanasia. The British Medical Association (BMA) is opposed to both physician-assisted suicide and euthanasia. It believes that ongoing improvements in palliative care allow people to die with dignity. The BMA argues that there are limits to what patients should be able to choose if their choice will inevitably impact on other people.

A previous attempt in the House of Lords to permit assisted suicide was Lord Joffe's Assisted Dying for the Terminally Ill Bill. That Bill was opposed by the Royal College of Physicians, the Royal College of General Practitioners, the Royal College of Psychiatrists, the Royal College of Nursing, the Royal College of Anaesthetists, the Association for Palliative Medicine of Great Britain and Ireland and the British Geriatrics Society. That represented a very powerful coalition of opposition from the medical profession to the legalisation of assisted suicide.

The UK is a world leader in the provision of specialist palliative care, helping patients and their families to cope with the physical symptoms and the emotional distress of advanced illness. We want to continue to strengthen the level of care that we provide to our older people.

Let us, for one moment, consider the experiences of the few countries that have legalised assisted suicide. The Netherlands formally legalised voluntary euthanasia and physician-assisted suicide in 2002. The practice of involuntary euthanasia is now well established in that country, with 546 deaths in 2005 as a result of lethal drugs not explicitly requested by the patient. In the state of Oregon, in the United States, physician-assisted suicide was legalised in 1997. That law has led to patients "doctor shopping" for willing practitioners, using doctors who have minimal knowledge of the patients' pasts and who may be ideologically disposed to fulfil the patients' requests for a premature end to their lives. That is not a road that we want to travel. That is not somewhere we want to go.

Mr Deputy Speaker: I ask the Member to bring his remarks to a close.

Mr Donaldson: I hope that the Assembly will unite and make it clear that we oppose the legalisation of assisted suicide or euthanasia in Northern Ireland.

Ms Anderson: Go raibh míle maith agat. The motion and the outworkings of the Purdy case have highlighted genuine and deeply held concerns on both sides of an extremely emotive argument. There should be a genuine and open debate on this issue to allow us to reach an informed opinion, and I am concerned that the motion requires us to adopt a position on assisted suicide before such a debate has taken place.

The motion seeks to tie the Assembly to what some might view as a fundamental position of opposing any attempt to legalise assisted suicide, but I do not believe that the decision by the DPP to issue guidance on assisted suicides represents an attempt to move towards legalisation. Rather, that decision is the legal outworking of the Debbie Purdy case, a case that cannot have failed to move all of us in the Chamber.

The case of Debbie Purdy is the case of a woman who suffers from primary progressive multiple sclerosis and who made a decision to end her life when her condition deteriorates to such a point that she can no longer live her life with dignity. She is seeking legal reassurance that her husband would not face prosecution for helping her to die. Remember: the penalty for helping someone to end their life is a 14-year jail sentence. There is no doubt that the House of Lords ruling on her case was significant and a turning point for the law on assisted suicide, but does it represent an inevitable step towards the legalisation of assisted suicide, as this motion seems to suggest? I do not believe that it is as black and white as that.

The Law Lords found that it would be a breach of Debbie Purdy's human rights for her not to know whether her husband would be prosecuted for accompanying her to the Swiss clinic where she wishes to die. The Director of Public Prosecutions was, therefore, required to issue a policy setting out when those in such a position can expect to face prosecution. We are now seeing those guidelines being issued: we are not seeing assisted suicide being legalised.

Let us not forget that there needs to be room for compassion within the law. We, as a society, need to ask ourselves what good it would do to jail Debbie Purdy's husband for 14 years for helping her to fulfil her wishes. We need to tackle such questions, not only in this Chamber but across society, by having an open and frank debate. It is for that reason that Sinn Féin tabled an amendment to the motion, calling on the Executive to conduct an inquiry into the implications of the Purdy case and the DPP decision and to report the findings back to the Assembly.

1.30 pm

Such an inquiry would have allowed us to make the informed, rational decision that is required. Unfortunately, Sinn Féin's amendment was rejected, and, in the absence of the necessary debate and discussion, we are being asked to adopt what some might view as a fundamental position.

In common with Jeffrey Donaldson, I am a carer; my family and I care for my mother who has had Alzheimer's disease for 10 years. I was appalled by what Baroness Warnock said. Although it has been challenging for us as a family, being able to care for our mother in our home has been a gift. As a family, we understand the illness. We would never countenance putting my mother into a home, let alone taking a decision that may, according to some interpretations, be available to us should the ruling be passed.

We must not adopt a knee-jerk reaction on assisted suicide; it is far too important for that. By not having the necessary conversations and not exploring all the possible ramifications, we fail to do justice to those, such as Debbie Purdy, who find themselves in tragic situations. For those reasons, Sinn Féin will abstain on the vote.

Mr Kennedy: I welcome the opportunity to participate in this important debate. The Ulster Unionist Party regards the issue as a matter of personal conscience, and, therefore, I speak as an individual. It is in the interests of parliamentary democracy that there should be a free vote to allow elected representatives to listen carefully to the debate and to vote according to their conscience.

Assisted suicide is not the act of an individual; it involves others, including family members and those in the medical profession. Furthermore, the legalisation of assisted suicide would involve the sanctioning of the act by society as a whole. Therefore, it is important not to regard the issue as one of respecting the rights of individuals. It is not about me and my rights; it is about us and our obligations to one another in society.

What would a change in the law mean for relationships in families, and between the medical profession and a patient and his or her family? It is my strong belief that, in the context of a terminal illness, the legalisation of assisted suicide could radically undermine those relationships. A family has a responsibility to love and to comfort during terminal illness, and central to a medical professional's vocation is the duty to do no harm. Both callings are challenged and undermined by the notion that a family member or medical professional can facilitate assisted suicide.

The present debate in the UK flows from the decision that the Law Lords made a relatively short time after Parliament had spoken definitively against suicide. That is not how the law in the United Kingdom or anywhere should be made. The courts exist to interpret law, not to make it. We should rethink our approach to, and investment in, palliative care. That should be a defining characteristic of what it means to be a caring society that cherishes the most vulnerable.

On a personal note, and reflecting on my experience and that of my family, we were blessed that my mother lived well into her 80s. In the latter stages of her life, however, she was considerably weakened by a series of strokes, and that gave rise to questions about her quality of life. Wherever mum was placed, whether in hospital or in nursing homes such as Avila in Bessbrook or the Sandringham Care Home in Portadown, the standard of care was not an issue. My family and I have the highest regard for all the staff, and we thank them for taking care of my mother.

However, at no stage did we, as a family, contemplate or even suggest that we should facilitate the premature ending of our mother's life. We wanted to cherish that life to the very end, however difficult that was. I believe that that is the view of the vast majority of people in Northern Ireland and I hope that it is the view of this Assembly. I respect those who have a different view, but that is how I see the issue.

Mrs Hanna: I thank the Members who tabled the motion. The SDLP has sympathy with the intent of the motion, although it is my understanding that the Director of Public Prosecutions (DPP) has issued guidance on whether prosecutions will take place in individual cases. The guidelines do not and cannot decriminalise assisted suicide, which is still illegal under the Suicide Act 1961. I welcome the fact that no advance guarantees will be given about whether to prosecute in individual cases.

The 1961 Suicide Act gave the final say to the DPP about whether there should be

prosecutions. I accept that prosecutors have to exercise discretion in their decisions and assess whether a prosecution will pass the public interest test. It is clear from the DPP's paper that charges are more likely if the victim is under 18 or mentally ill, or if the suspect stood to gain, financially or otherwise, from the death of the person in question. It seems likely that serial assistors will be prosecuted, as will members of groups such as Dignitas, whose main purpose is to facilitate suicide.

I have four main concerns about the guidelines. First, they apply at home and abroad, so they apply to people who travel to Switzerland. They also encompass suicide by the seriously ill as well as the terminally ill. By the seriously ill, I mean a person who may suffer from a severe and incurable physical disability or a severe degenerative physical condition from which there appears to be no recovery, but who may not be terminally ill. The term "seriously ill" covers a wide range of medical conditions, including chronic heart disease and most kinds of physical disability. However, the way the guidelines are written suggests that the lives of a whole group of people who are seriously ill or disabled are less deserving of the protection of the law than others.

Secondly, I am concerned that the prosecution of spouses, partners, close friends or family members is envisaged as being less likely than the prosecution of others. There is a danger that that could give the green light to assistance from close relatives or friends, who, in many cases, may be those who stand to gain personally from the death of the person in question.

Thirdly, I am concerned that the discretion of prosecutors will be accepted as the norm rather than the exception. To my mind, that usurps the function and prerogative of this legislative Assembly. Assuming that policing and justice powers will be devolved, this is an issue that will have to be faced up to and on which leadership will have to be given. With all due respect, nobody elected the DPP.

Fourthly, this Assembly has often debated the issue of suicide, particularly among young people and in urban and rural areas of economic and social deprivation. Recently, there were a reported 30 suicides in the North in one month. Although we have a suicide prevention strategy, I am concerned that those guidelines could inadvertently contribute to sending out the message that although we have policies for combating suicide among the young and other vulnerable groups, assisted suicide, in other cases, could be acceptable.

I do not minimise the distress of families and friends who watch a loved one who suffers from a terminal illness or whose personality crumbles under the ravages of Alzheimer's disease or similar conditions. However, we must have consistency. In relation to the issue of unbearable physical pain for the terminally ill, there have been tremendous advances in palliative care in recent years, and I pay tribute to the work of hospices and others. There is also much more emotional and practical support that is given by dedicated professionals to family and patients.

I agree with the science fiction author Terry Pratchett, who suffers from Alzheimer's disease, that we should devote more resources to help to find cures.

The SDLP's fundamental ethos is grounded on civil and human rights, and the most important right of all is the right to life. Our outlook has been shaped irrevocably by

the terrible conflict that the North has had to endure for more than three decades. A primary purpose of the law in any ordered society is to protect human life. In the past, the unique value of human life has too often been disregarded. Our belief that the right to life is paramount will certainly inform our response to the motion.

Mr Ford: At the outset, I emphasise that, given that my party regards assisted suicide as an issue of conscience, I speak in a purely personal capacity.

I also do so because of the personal circumstance in which I, like other Members, find myself. Within a little over two years my mother and my mother-in-law both died. Both died in their own beds, in their own homes, surrounded by family and after relatively short illnesses in which they did not suffer greatly. For that, we are extremely grateful. One should be very grateful that somebody can have more than 90 years of a happy life and die secure in their faith without suffering.

We must recognise that that is not the case for everyone in society. I am not talking about examples such as that which the proposer of the motion gave when he talked of his brother. The issue is not one of saying whether any particular person's life is worthless. However, difficulties arise that must be taken into account. One such example is the Purdy case, which involves someone who is clearly fully mentally competent and who recognises the suffering that may lie ahead. In such cases, the person involved may not share the faith that sustains others.

It seems to me that the key element is to ensure that guidelines are in place to meet those difficult circumstances with compassion while protecting the vulnerable. I do not doubt that in some places where assisted suicide has been legalised, the pressure builds up and assisted suicide becomes the assumed outcome and not just an option for those who wish to choose it. We should oppose absolutely people's being pressurised in that direction. Therefore, I agree with the opposition of the Members who tabled the motion to any question of legalising suicide in our society.

However, it was a little unfortunate that, when moving the motion, Mr Donaldson used the term "euthanasia" a couple of times. My understanding is that euthanasia is an active process of what might be described as mercy killing. I believe that there is a slight difference between the terms "suicide" and "assisting suicide" that is not accounted for fully in the language that he used.

Mr Donaldson: I was not trying to liken assisted suicide with euthanasia; my point was that there is a very fine line between the two, and that if one were legalised, the inevitable consequence would be the legalisation of the other.

Mr Ford: I thank the Member for that clarification. I may not agree with his use of the word "inevitable" but I can certainly accept his point about there being a narrow line.

Other Members talked about the clear need for us to ensure that better care, including palliative care, is provided for many people with long-term illnesses. We heard already in the debate of examples of places and of family circumstances in which people with particular long-term needs are well cared for. The reality is that as a society we may or may not resource acute hospital services well. We do not, as a society and in general, resource community care and palliative care nearly as well as we should.

To some extent, the debate is not quite about the current legal situation. I have stated my opposition to any question of legalising assisted suicide, but we now have the DPP's guidelines of the circumstances in which prosecution would be considered. Those guidelines make it clear that the process for prosecuting assisted suicide cases is exactly the same as that for any other criminal case. First, there is the evidential test, which, in itself, may not be entirely clear. That is the situation in the Purdy case. Secondly, the public interest is tested. I would certainly not stand over the guidelines for the latter test in every sense as they are promulgated, but I believe that they are a reasonable attempt to recognise that there will be a small number of extremely difficult circumstances in which prosecution will probably not be in the public interest.

In circumstances in which someone who is deeply affected by their love for somebody who is suffering gives that person a relatively small amount of assistance to carry out what is clearly an intended suicide, we have to recognise that there are real public interest issues in pursuing such a case to the full extent of criminal law.

1.45 pm

The Director of Public Prosecution's guidelines are a reasonable attempt to take account of such circumstances. Nevertheless, rather than the majority of Members simply saying, as I expect, that they are opposed to legalisation, we should debate them in more detail than one can manage in a five-minute speech in this place. There are difficulties with how guidelines might be applied on the issue of whether prosecution is in the public interest that must be discussed, not just by lawyers and doctors but by wider society, of which we are representatives. With that caveat in mind, I accept what the proposer of the motion has said, but this debate should not be the end of the matter.

Mrs I Robinson: I am grateful for the opportunity to speak on the motion. As Members have already said, this is a very serious matter. Society has a duty of care to the sick and vulnerable, especially the aged population. Therefore, the guidelines recently published by the Director of Public Prosecutions are worrying. The law should uphold the sanctity of life, without any equivocation.

Why do our legislators always seem to rush head-on to accommodate a vociferous minority, regardless of the overwhelming body of evidence that opposes its opinion, either on a Christian or a moral basis? Moreover, how many of us have heard our elderly parents say at some stage in their lives that they are a burden on everyone? Down the line, such words could become a green light for someone to believe that they are helping their elderly parent by offering a way out. Some people could abuse that, and, unfortunately, we have seen people in ordinary criminal circles manipulate others because they have, for example, a lot of money in a bank account or a property. Why would they not do the same in respect of this matter?

I am also glad to take this opportunity to applaud the work of the palliative care nursing profession, all of whom give wonderful service and display devotion and commitment to the terminally ill. I call on the Minister of Health to do his utmost to improve palliative care services for the terminally ill and those who are suffering great pain.

On publishing his guidelines, the Director of Public Prosecutions, Mr Starmer, said:

"There are also no guarantees against prosecution."

I welcome that statement, but he also suggested that the guidelines will provide people with enough information to make informed decisions. I want to know what he actually meant.

Dr Peter Saunders from Care Not Killing said:

"There must be a real danger that this will be seen as giving the green light to assistance from close relatives or friends."

As I said, I share that concern. The guidelines have not changed the law, but I am worried that they give people something on which to fall back should they help someone to end their life. That position should be clarified.

Among the factors in the guidelines that determine prosecution, it is worrying that the Director of Public Prosecutions suggests that having the guidelines written down could lead to people helping their loved ones to take their own life in due course.

We must oppose any move to introduce to the United Kingdom any form of law that permits a person to help to take someone else's life. I am morally opposed to any such legal idea, which throws up many challenges. If such a law were passed, what would constitute murder? Anyone who takes someone else's life in cold blood could claim that they were asked to by that individual. That scenario is particularly relevant to the elderly or physically disabled.

Assisted suicide also throws up many social issues. If we get too old or too sick, will we face pressure to take our own lives, as a result of the fear that we will be a burden on our family and friends? Furthermore, any move to legalise assisted suicide will put those in the medical profession under extreme strain, for, on entering the service, members of that profession take an oath to save and preserve human life.

The number of those who die as a result of assisted suicide in Europe is growing, but I am thankful that it has not reached the same level here. I am happy to stand with my colleagues in supporting this important motion.

Mr O'Dowd: Go raibh maith agat, a LeasCheann Comhairle. The tone and manner of the debate reflects how personal an issue this is, both to us as legislators and to society at large. What strikes me is that, even in our own minds, Members do not have the answers to all the questions raised. That is true even of those Members who have taken time to research the subject, are involved in the issue in other legislatures, have been lobbied more strongly than other Members or have been involved in the debate over many more years than most through their politics, their Church or other aspects of life.

Many questions on the subject remain unanswered. That is why, as stated by my colleague Martina Anderson, my party will abstain from voting on the motion. The debate almost finalises the issue: the Assembly has spoken, and this is the way it will

be. In my party's view, we need to begin a debate on the subject of assisted suicide and allow all sections of society to be heard on this most sensitive subject. It is about how our loved ones wish to deal with illness and becoming old and infirm. That is what we are talking about: people who find that someone with whom they have spent their life and whom they love deeply has reached a stage where he or she can no longer continue because of illness or infirmity.

As has been pointed out, the Purdy case highlights many of those issues. A young woman who has all her mental capabilities intact decided that she wanted to bring to an end her suffering and went through a legal process to ensure that her husband would not be prosecuted for involvement in that. Mr Donaldson said that some who ask for assisted suicide have strong mental capabilities but that there are others in a similar position who cannot make such a decision for themselves. Those are the people whom we must protect.

The question is asked whether, if we introduce assisted suicide, it will open a door to many other things. I hope and expect that those questions have been asked in other countries and legislatures that have introduced assisted suicide, and that those jurisdictions have introduced safeguards to protect the vulnerable and the loved ones of those who have decided to take that path and to ensure that assisted suicide does not become a byword for murder. We all want to avoid that and to ensure that those who have reached such a decision are not treated badly or abused by close relatives or friends who are motivated by the prospect of financial gain.

We must also ask ourselves whether, if we talk openly about or legislate to allow assisted suicide, we damage all the energetic work and campaigning that we have put into that other aspect of suicide, namely, its prevention. Does that open up a new debate? Does it legitimise suicide?

In saying that, I am not saying that anyone has committed a crime or, in my opinion, a sin for taking their own life. No one knows what pushes that final trigger in someone's head when they decide to take their own life, and I will not sit in judgement on anyone on that issue.

Another question is whether assisted suicide means that suicide becomes more frequent. I do not know the answer to that. It is difficult for me as a legislator to make a decision on a subject that we have only started to debate. Until those questions are answered in my head, the debate has taken place in public and all sections of society have made their voices heard on the subject, the Assembly should not be making a decision, even during or after a private Member's debate. We need to ensure that, following today's debate, we open up the public forum; that, in six months or a year, we return to an informed and sensitive debate — and today's debate has been sensitive — on the subject of assisted suicide; and that we approach it with open minds.

Mr Wells: It is seldom that the Assembly deals with such a serious issue. I will not be my normal, chatty self in this particular debate because it is such a serious matter.

Yesterday, I had the privilege of attending an event that was organised by Life After Loss at Belfast Castle, which was supported by more than 1,000 people who had lost

children through a miscarriage, stillbirth or death shortly after birth. It was an extremely poignant event as we launched 1,000 balloons, each with the name of a child who had been lost in those circumstances, into the sky. Not only was it poignant but there were many tears. That event emphasised to me, once again, how sacred life is.

My view, which I am sure is the view of many people in Northern Ireland, is that life starts at conception and ends at a natural death and that the only being who can or should control that is the Almighty. Northern Ireland is different from the rest of the United Kingdom and, indeed, probably from the rest of Europe in that we hold, as a community, to strong Christian values. We do so whether we are from the evangelical Protestant, the Roman Catholic, or even the liberal Presbyterian tradition that I know that Mr Ford comes from. We hold to those views as something that we will lose at our peril and that is very dear to us.

Therefore, there should be no question of any change in the legislation in Northern Ireland on this important subject; just as the Abortion Act 1967 should never be introduced in Northern Ireland. That legislation may be imperfect, confusing and difficult to interpret but it has worked — it has acted as an impediment to abortion, as the present legislation clearly acts as an impediment to assisted suicide.

Recently, we have all heard about the tragic case of Gareth Anderson in the Ulster Hospital. The initial prognosis was that Gareth's condition was extremely serious. I am delighted to say and we are all pleased to hear that, as a result of the skill of surgeons and a lot of prayer, Gareth's condition has improved dramatically and there is every prospect that he may make a reasonable recovery. That is good news. However, that case shows that the initial prognosis can be wrong. A very serious diagnosis can be made, and then, as a result of prayer, natural healing or the skills of surgeons, the situation can be turned round.

In Newcastle, in my constituency, there is a famous case of a clergyman's wife, Mrs Mackay, who was diagnosed as being terminally ill with cancer and was given absolutely no hope six years ago. That lady is now out and about giving talks to church congregations throughout Northern Ireland about the benefits of faith healing. Therefore, it is wrong to assume that, because someone has had terribly bad news, it is terminal.

Like other Members who spoke in this debate, I am extremely worried that a right to die could become a duty to die — that older people may be placed under huge pressure to do the honourable thing, as it were, because they are considered to be a burden on society or to the family. There is precedence for that. We have often heard in the courts about elderly people who were pressurised by their families to change their wills.

How many times have such cases been fought in the courts? Last Friday, in fact, the court ruled to revoke a will under which someone had left £2 million to the RSPCA, and it was believed that pressure had been exerted in that case. If such behaviour goes on during the writing of a will, what might happen as the burden of residential or care at home, in particular, weighs heavily upon a family? It is possible that they will come under pressure from the unscrupulous to do the "honourable thing" and subject the elderly person to some form of assisted suicide.

2.00 pm

Northern Ireland is well served by the present arrangements. I am not certain of the legal situation; it would be useful if Mr Hamilton, in his summation, informed the House whether the issue is the call of Northern Ireland, through the Executive or the Department of Health, Social Services and Public Safety, or whether direct rule Ministers acting on behalf of the Parliament in Westminster can inflict it on us. It would be useful to know exactly where we stand. Most people in Northern Ireland do not want to see any move or significant change in the present situation on this highly emotive issue.

Mr Kinahan: I am glad to be able to speak on such a serious issue. However, the motion muddles matters and does not demonstrate an understanding of what is going on. The DPP's decision to issue guidance is an effort to simplify the issue so that we will understand the rules; it is not an attempt to legalise assisted suicide. I agree that we need to look into the matter in more detail.

We should thank Sir Alasdair Fraser for putting together the guidelines and for clarifying matters, as we do indeed know when to prosecute. We should praise the Purdys. If we think of the absolute hell that they and many others must have gone through, we will appreciate that this is a chance for people to consider how they are to cope in future.

If I may go for a slightly lighter tone for a second, may I say that many of us might feel that appearing on 'The Stephen Nolan Show' or coming here is assisted suicide. However, I do not want to joke too much; this is a very serious matter, and I do not want to see it perverted by us thinking truly down Christian principles. It may be Christian to allow things to happen, and we must not force our religious principles down other people's throats, as, it seems, is the case with a motion that will be debated later today.

There will be rare occasions on which we will need the guidelines. We need better care and debate, but think of those people who, nobly and bravely, are suffering complete and utter agony. If we prevent them from finding a release from that agony, we are no better than the Gestapo. The issue is not about rights; it is about freedom. It is about the freedom of choice for a very small minority. Today, I hope that Members will remember that rare cases will arise, and we should not condemn everyone by misreading the guidelines. Choice is a bedrock of our society, and the motion is too dogmatic. I do not support the motion, and I agree that we should have further debate.

Mr A Maginness: I come from a constituency that is labouring under the horror of many suicides, particularly among young people. What sort of message do our arguments on assisted suicide send to young people who are suffering under stress? I understand the inevitability of the DPP issuing guidance on assisted suicide following the Purdy case, where the House of Lords indicated that there ought to be guidance or assistance on whether to prosecute. However, I am uncomfortable with some aspects of the interim guidelines.

I do not blame the DPP for Northern Ireland, Sir Alasdair Fraser, because he is an honourable public official who is carrying out his public duty following the decision of the House of Lords. However, his interim guidelines on the public interest factors against prosecution for assisted suicide sit uncomfortably with those who are opposed to assisted suicide becoming permissible under the law. He makes it clear that there will be no change in the law and that it is not the intention of the guidelines to make such a change.

The first of those guidelines requires:

"The victim had a clear, settled and informed wish to commit suicide."

How can the DPP or anyone else come to that conclusion? How does one define or determine a victim's state of mind? The fifth guideline requires:

"The suspect was wholly motivated by compassion."

"Wholly" motivated, as opposed to "partly" motivated, by compassion is also difficult to define. The sixth guideline requires that:

"The suspect was the spouse, partner or a close relative or a close personal friend of the victim, within the context of a long-term and supportive relationship."

Is that guideline helpful, and does it really assist us in determining whether a prosecution should be brought? Surely those who are closest to the victim are the people who have suffered the most and are the most likely to carry out an action that could bring about suicide.

Although the DPP's guidelines on assisted suicide are well intended, there are some difficulties. The public have been given an opportunity to air their views on the guidance during the consultation process, and I encourage them to do so.

Although the guidelines will not change the law, they could muddle it. The law entrenches certain values, and, when one begins to change the law, those values are undermined. It is important that the law supports the right to life. I believe that life is a sacred gift. I do not believe that it should be interfered with, and nor do I believe that a person has the right to end his or her life.

Mr McNarry: It is always interesting to hear Mr Maginness being subjective, and I thank him for being so during his contribution.

I also share his belief in the right to life. Does the Member feel that that right is not being dealt with in the guidelines? Will he suggest a way in which it could be dealt with? There are those who believe that that view, because it is not written in the guidelines and, therefore, cannot be read or pointed to, has been set aside.

Mr Deputy Speaker: Order. I remind the Member that interventions should be as short as possible.

Mr McNarry: You are quite right to remind me of that. I am looking for the Member's professional guidance as to how —
Mr Deputy Speaker: There will be no time for an answer if the Member does not hurry up with his intervention.

Mr McNarry: Does Mr Maginness think that the right to life should be included in the guidance?

Mr Deputy Speaker: The Member has 10 seconds left.

Mr A Maginness: That is an extremely difficult question to answer. All that I can say is that if the law remains unchanged —

Mr Deputy Speaker: The Member's time is up.

Mr A Maginness: I thought that I had an extra minute.

Mr Deputy Speaker: You have got the extra minute.

Mr A Maginness: I have or I have not?

Mr Deputy Speaker: You have; yes.

Mr A Maginness: I believe that, if the law remains unchanged, the criminal offence of assisting suicide is a certainty.

Mr Deputy Speaker: The Member's time is up.

Ms S Ramsey: As John O'Dowd said earlier, this has been a sensible and sensitive debate. It is always useful for the Assembly to have the opportunity to discuss important issues. I agree with the part of the motion that states:

"That this Assembly notes the verdict in the Purdy case".

However, I also think that any decision made by any Government — including our Executive — should have an input from the community, and it is useful that there will be a consultation exercise. We should, through our offices and constituency networks, encourage people to get involved in the consultation exercise and to respond to the documents.

There appears to be some confusion, even during this debate, over points that have been raised, and Members have raised a wide range of opinions on the issues. Nevertheless, the key message from all Members is that we must ensure that we protect the most vulnerable, no matter what. The most vulnerable people should be uppermost in our minds, and it is important that that message gets across. It is very hard, during a debate that lasts an hour and a half, or during a five-minute contribution, to get that message across, and only the sound bites come out in the media. The clear message today is that we must protect the most vulnerable in our society.

The interim guidance states that the consultation will run from 16 December and a final policy will be published in the spring of 2010. Sinn Féin tabled an amendment so that the Executive could become involved. What input will the Executive Ministers, including the Minister for Health, Social Services and Public Safety, or the Committees have? This is a fundamental issue. Members spoke earlier about the need for personal choice and for free votes. However, it is important for the Executive to be involved.

The press release issued with the guidance states that it:

"identifies those public interest factors which must be weighted both for and against prosecuting someone".

Members who spoke previously highlighted the confusion in that area. Many people have strong views both for and against assisted suicide. Therefore, it is important to have a consultation exercise. A recent press article stated that the will of the people will be listened to. There should also be input from the Health Minister and the Health Committee, which should have a role and be able to respond. Therefore, it would be important for the Committee to have a copy of the consultation documents.

The Debbie Purdy case has raised important issues and important questions. However, everybody should arm themselves with the facts. No one takes the issue of assisted suicide lightly. We commend carers, but we must follow that up. Carers who look after loved ones are sorely underfunded, and they are not getting the proper care package or the financial support that they need. That issue must be looked at.

Families of a loved one who has taken his or her life have campaigned long and hard to remove the stigma that he or she "committed suicide". Those families believe that their loved ones did not commit a crime, and we should be sensitive to the needs of those families.

I also believe that it is a matter of personal conscience; Danny Kennedy mentioned that earlier, as did a number of other speakers. It is important that people come to the decision armed with all the facts.

2.15 pm

I want to end on this note: I hope that no one here finds themselves in the position of being asked to assist a loved one to commit suicide. The clear message that should be expressed is that there is always hope, and that we should never lose hope. Go raibh maith agat.

Mr Easton: I support the motion on a most vital matter, namely, the sanctity of human life. It is, I would contend, a matter of principle to seek to support, to nurture and, most importantly, to protect human life. Can any of us envisage where it would end, were we to devalue the principle of the sanctity of human life? Is it a folly to suggest that we could end up in a situation in which, as a society, we would tell people with serious life-limiting conditions that we do not deem it appropriate to use financial resources to sustain and prolong their lives, but that, when they are ready, the Government will assist their suicide? I believe that that would be wrong.

That is the reality of what is happening in the state of Oregon in the United States. A lady there named Barbara Wagner, who had lung cancer and was on Medicare, the state health insurance system for the poor, was given the message that she would be denied certain forms of medical treatment, but that the state would pay for her assisted suicide. That is wrong.

A similar thing happened to Randy Stroup, who had prostrate cancer. Perhaps it is appropriate to listen to what Mr Stroup had to say verbatim:

"It dropped my chin to the floor … not pay for medication that would help my life, and yet offer to pay to end my life?"

Those are sad words, which make us confront the importance of today's debate.

As I understand it, the decision in Mr Stroup's case was reversed on appeal, and Mrs Wagner was subsequently supplied with free medication by the drug manufacturers. However, those two cases show what can occur to people in our time, in a state where the authorities assist suicide. We must be ever vigilant to ensure that vulnerable people in our society are not pushed around, cajoled or — let us be frank — bullied into the termination of their lives because they are led to believe that, due to their life-limiting illness, they are a drain on society's financial resources and that their care is some sort of affliction and burden that their loved ones have to bear.

The British Medical Association (BMA) states that it:

"has long advised doctors — for moral as well as legal reasons — to avoid actions that might be interpreted as assisting, facilitating or encouraging a suicide attempt."

If that were not explicit enough, it goes on to state:

"The BMA remains opposed to doctors taking a role in any form of assisted dying."

I contend that those directions are not given lightly by medical experts; rather, they are the conclusion arrived at after detailed analysis of the expertise of the medical profession. Although no one has the monopoly on wisdom, only a fool would consider lightly the direction of the BMA.

In conclusion, what is the situation for a person with depression who seeks assisted suicide? Are patients in that situation given the necessary psychiatric care and support? The experience of Oregon would appear to suggest otherwise, as physicians there can assist suicide without considering the psychological aspects. Is that where we wish to go? I do not believe so.

Mr Ford: I appreciate the Member giving way. I wonder whether he has actually read the guidelines, because, as I read them, it was absolutely clear that a case that involved any question of a psychiatric illness would tend to result in prosecution.

Mr Easton: I thank the Member for his intervention, and I take his comments on board.

I argue for a better way, where the psychology is changed from suffering from a life-limiting condition to living with a life-living condition, where there is effective palliative care and the sanctity of human life is upheld, promoted, and, most important of all, protected. In supporting the motion there is no better conclusion than that of the assistant director of the International Task Force on Euthanasia and Assisted Suicide, Wesley Smith, who stated, when referring to Oregon:

"legalising assisted suicide leads to abandonment, bad medical practice and a disregard for the importance of patients' lives."

Life is sacred, and only God can decide when we go from this life.

Lord Morrow: I support the motion. Some interesting comments have been made, not least the confusing ones, particularly Mr Kinahan's. I could not make up my mind, and I suspect that he could not either, whether he supports the motion, is against it or is neutral on it. Perhaps some day he will tell us.

I agree thoroughly with the view that has been expressed that human life is God given and can be terminated only by the giver of life. Suicide, in any form, is wrong. It would be a sad day for Northern Ireland if assisted suicide were legalised and legislated for here. Carmel Hanna said correctly that, one day, the Assembly will have to stand up on the issue. I look forward to that day.

We are faced with sad statistics about people who simply feel that they cannot bear another day alive and who are driven or are drawn to take their own lives. Generally, that leaves a gulf of unanswered questions, recriminations and, of course, tremendous grief. We have campaigned for support and funding for the individuals who have simply come to the end of their tether, if I may use that expression. However, I accept fully that the issue of assisted suicide is in a somewhat different category. We are told that the people involved have made the conscious decision that they no longer wish to suffer from a crippling, debilitating illness that has left them without hope or dignity. Therefore, a degree of sensitivity must be exercised when challenging the topic.

On completing training and before stepping out as fully fledged practitioners, doctors take the Hippocratic oath, which has formed the backbone of medicine for centuries. Its emphasis is on preserving life at all costs, treating the condition where possible, and, whenever they are successful, making the patient well. Whenever that cannot be achieved, the oath remains a powerful ethic by ensuring that the suffering of patients is kept to a bare minimum.

We are told that two doctors are required to examine a potential assisted suicide patient to determine whether their condition is terminal and degenerative and to decide whether they are of sound mind. We are told that strenuous enquiries will be made to ensure that the patient has not been put under any financial, emotional or physical pressure.

However, a closer look reveals that the only requirement on the two doctors is that they be registered. That means that they could be qualified for as little as one year.

Such doctors would have gained very little on-the-job experience. Much of a doctor's career is spent learning from such experience and putting into practice tried and tested methods over and over again. A doctor with one year's experience would not be remotely close to having gained enough pertinent knowledge of life and death.

Furthermore, to examine such cases, a doctor will not be required to have any specialised background on the patient's condition or illness. They will need neither any particular ability to assess the patient's mental health nor the experience to determine whether a patient has been forced into such a position.

Each doctor will see the patient only once. No doctor, even a highly trained and experienced consultant, could possibly draw conclusions on a matter of life and death after one sitting. The two doctors must, of course, be paid for their time. The criteria for assisted suicide are fundamentally flawed and fall far short of the core of the Hippocratic oath and society's duty to care.

When the Abortion Act 1967 was introduced, similar arguments were made that it would not open the floodgates. Let us consider that, some seven million abortions later.

Mr Wells: Will the Member agree that David Steel, who introduced the Act in 1967, said that it was intended only to clarify the confusing and difficult cases? He managed to clarify the 2% of difficult cases by introducing an Act that led to the deaths of seven million unborn children. Can the Member see the same danger with potential legislation on assisted suicide?

Lord Morrow: I thank the Member for making that point. I could not agree with him more.

I trust that the Assembly will take a long hard look at such issues when the day comes for it to make a decision. Now, we can see the extent to which legislation that was introduced to accommodate difficult cases has been abused. Much more could and should be said about that. I see that my time is nearly up.

Some people say that there is no comparison between euthanasia and assisted suicide. I disagree; there is a comparison and a frightening closeness. Recently, someone on the Benches opposite said that this is a fundamentalist's viewpoint. It most certainly is not. The BMA made its position clear recently, and it is also opposed to assisted suicide.

I am pleased that no one in the Chamber strongly feels that assisted suicide should be legalised. I hope that the House supports the motion unanimously.

Mr Deputy Speaker: Order. Question Time will commence at 2.30 pm. Therefore, the debate will resume at 3.30 pm when the first Member to speak will be Alex Attwood.

The debate stood suspended.

3.30 pm

Private Members' Business

Assisted Suicide

Debate resumed on motion:

That this Assembly notes the verdict in the Purdy case and the decision by the Director of Public Prosecutions in Northern Ireland to issue guidance on assisted suicide; and states its opposition to any attempt to legalise assisted suicide. — [Mr Donaldson.]

Mr Attwood: I broadly welcome the tone and content of many of the contributions to the debate before Question Time. Before dealing with the particulars of the motion, without prejudice to the guidelines that the CPS and the PPS have issued, I shall make a broader point.

I welcome it when the prosecution authorities in the North begin to develop policy and issue public statements about what their policy might be when prosecuting offences. That is a welcome development, and it sets a useful precedent, because, whatever one may think about the guidelines, there are too many vacuums in the administration of justice and in the prosecution of offences for the PPS in the North and, I dare say, the CPS in England not to publish more comprehensive reasons for and policies about when cases will be prosecuted or dropped. Indeed, as I understand it, the PPS in Belfast is about to publish a new policy that gives reasons why cases may collapse or be withdrawn or why charges may be reduced. In that regard, I have been saying to the PPS that it should not publish those guidelines until there has been further consultation with victims and witnesses. Nonetheless, the publication of policies and the giving of insight into why the PPS makes decisions about certain matters is a useful and welcome development.

A number of colleagues, including Mrs Hanna from South Belfast, expressed concerns about the guidelines' content. I have no doubt that the CPS in England and, more particularly, the PPS in Belfast have listened to those concerns. Therefore, if issues arise about the level of discretion that the PPS may have in deciding whether to prosecute a spouse who assists a suicide or about assisted suicides for those who are seriously as opposed to terminally ill, I trust that the new guidelines will be clarified or strengthened in order to address those concerns. Moreover, I trust that this debate will be reflected in the consultation that PPS is undertaking.

Having said that, I think that the Assembly will have to get its head around the matter and similar matters, especially in the context of the devolution of justice powers. John O'Dowd and Martina Anderson in some way dealt with that point. When it comes to matters such as assisted suicide, people in the North have, in effect, three choices. First, we can pass laws that create absolute offences, whereby anybody who assists a suicide will be prosecuted and appear before a judge, in which case a judge will have the discretion to decide what penalties are laid down, which could end up being a minimum penalty. Even an absolute or conditional discharge for assisted suicide may not help public confidence or move public debate forward. Secondly, we do precisely what happens now; namely, the PPS, consistent with the law that governs the matter in Northern Ireland, should develop the tightest possible guidelines to

legislate against any possible abuse in assisted suicide cases. Thirdly, after the devolution of policing and justice powers, the Assembly could legislate on the matter, creating the context, guidelines and certainty for assisted suicide to reflect views in the Assembly and public opinion in the North.

Those are our alternatives. People may not like the CPS/PPS route for moral or legal reasons, but it is probably the best way of creating certainty and best practice rather than leaving it to judges to decide what penalties should be imposed or to the Assembly to create law that would have to take into account variable factors such as the public interest and other matters.

Mr Deputy Speaker: Will the Member bring his remarks to a close?

Mr Attwood: I welcome the debate and hope that the Assembly returns to this matter and deals with suicide and assisted suicide in a much fuller and more rounded way.

Mr Shannon: The matter is an emotive one and it is easy to get carried away; I may be one of those sometimes carried away by emotion. However, sound judgements are not usually based on emotional responses. There is a saying: hard cases make bad law. That has been tried and tested over many years' and I believe it to be true.

A hae a strang belief i the sancity o' life. A alloo at we hae laas fer gye guid reasons an' tae let ithers bae i a position o' dictatin' life an' death isnae a healthfu' position fer simboadie tae bae in. In es mich es we'd like tae think at loved yins an femmelie members onie iver hae oor bes' intherests aa hairt, they can bae swayed bae emotion an bae ither less worthy motives.

I believe firmly in the sanctity of life and that we have laws for good reasons. To allow others to dictate life or death is not a healthy position for anyone. As much as we would like to think that loved ones and family members only ever have our best interests at heart, they too may be swayed by emotion and other less worthy motives.

Recently, I read an article by the Reverend Ian Galloway that succinctly expresses much of the fear and reservation that should be taken into account when considering the legalising of assisted suicide. The author states that a certain camp seeks to change our law so that the state will be given the authority to stamp "suitable to die" on some people. It goes on to state that we are assured by those who advocate assisted dying that it will be tightly controlled, well policed and not open to abuse. Vulnerable people, they assure us, will not feel pressurised into taking an option with which they are not entirely comfortable. After all, we are a civilised society, or at least that is what they say. However, more than 200 people a year starve to death in NHS hospital wards and, tragically, people fall through all those safety nets. Can it be guaranteed that legislation with the express purpose of bringing about the deliberate killing of a human being will never be misused?

Many were shocked by the views of Ludwig Minelli, the lawyer who founded the financially opaque Dignitas suicide clinic in Switzerland, where one may be charged £2,500 to £6,000 for the privilege of undergoing assisted suicide. He defended the decision of his non-profit-making organisation to assist in the suicide of a healthy young woman and talked of the "marvellous possibility" presented by suicide and of

the burden placed on the NHS by those who have attempted suicide and failed. Does that vision really represent the route that this country wants to go down or the kind of society in which we want to live? The Royal College of Nursing now takes an officially neutral stance on the issue, but the British Medical Association and the Academy of Medical Royal Colleges continue to oppose assisted dying. The most recent and comprehensive survey of doctors in the UK shows a large majority of medical professionals against it.

Tragically, large numbers of people choose to end their life. Our response should not be to encourage and help people along that route but to offer care, support and a listening ear.

I also read of a survey of 7,000 doctors that reveals that the group of clinicians most strongly opposed to any form of assisted dying is palliative care specialists: the doctors who deal most closely with people at the end of their life. We should take note of that as well.

If we allow our feelings of pity to endorse a case where a husband assists his dying wife to end her life sooner, what will happen in the case of a father who has a child with an expected lifespan of five or six years? Can that father rightly assist the child to die sooner rather than later? Do we discount the life-saving breakthroughs that medicine delivers daily? Do we discount the hand of an almighty God? My colleague Jim Wells mentioned the case of young Gareth Anderson. Gareth lives in my constituency, and I worked with his father. To those who do not believe in miracles I say, “If ever there was a miracle, that was one”.

My answer to all of those questions is a resounding no. As is often said, this is a slippery slope, and we cannot let it go too far. The legalisation of abortion has led to thousands of perfect children being killed every month on the mainland because they are an inconvenience. How long will it be before it becomes inconvenient to pay for a nursing home for an elderly relative? Where do we stop?

We have heard what other Members have said on the subject. No matter how people try to rationalise assisted suicide, it can never be a good thing for society as a whole, and we will stand against it in this Chamber. I urge Members to support the motion; it has been moved for the best reasons. Assisted suicide is a moral issue for many people in our society, and we must support the motion.

Mr Hamilton: Like Mr Shannon and Mr Attwood, I thank Members not only for their contributions to the debate but for its tone. Given that this is an extremely emotive subject, the emotion of which could easily have spilled over into the Chamber, the manner of debate has been good and helpful towards having a worthwhile discussion. It was noticeable that a number of Members spoke not only of general cases of which they are aware but of personal cases in which their loved ones have had very challenging conditions that have made the latter days of their lives very difficult for them and for their families. The personal experience that Members brought to the discussion was helpful to the debate.

For me, as for many people, the subject of assisted suicide was brought into focus when the verdict was reached in the Purdy case early in the summer. What particularly irked me was the joy with which the verdict was met by some. It was a

verdict not on a libel case or on the awarding of damages for an accident but on a case that had profound and far-reaching implications for how we, as a society, treat our fellow man. That is why the issue deserved much more respect than was, perhaps, shown by some in the immediate aftermath of the case.

I concur with the comments made by Mr Kennedy; it also worried me that we were seeing another example of potential legislating from the bench. That is not the way that law is or should be made in this part of the world. Law is supposed to be made by legislators such as us and enacted in the courts by the judiciary, not made by the judiciary itself.

Inevitably, the verdict in the Purdy case has been latched onto by those who have had a long-standing agenda of legalising state-sponsored suicide and who see it as an opportunity to achieve that agenda. Although I understand Mr Attwood's point about the guidelines — in many respects the Public Prosecution Service has been put in the unenviable position of having to issue them — and I disagree fundamentally with that guidance or the points contained in it, I understand the position into which the PPS has been put by the verdict in the Purdy case. Many of us regard the guidelines as the slippery slope or the thin end of the wedge towards something much worse than guidance on when somebody may be prosecuted for assisting in someone else's death. That is the real fear.

I also understand that the issue of assisted suicide is not black and white. I may see it as being black and white, but I know that a great many others do not. However, I believe that the vast majority of people in the UK, particularly in Northern Ireland, are opposed to any liberalisation or attempted liberalisation of the laws to allow for assisted suicide or, indeed, for the turning of a blind eye to it.

The greatest fear that I have with any move towards liberalising the law on assisted suicide in any way, shape or form is not for those articulate individuals who are seen as the face of assisted suicide, calling for changes in the law to allow it to happen or for those who assist not to be prosecuted. My fear is not for that group of people, who are clear in their views and espouse them articulately, but for the wide number of others, the vulnerable in our society. If we move to a situation in which assisted suicide is legal or a blind eye is turned to it in this country, it raises the question of what happens to the elderly, those with dementia, those who are very ill or even those who are depressed. Allied to that, I have another question: what about the individuals who exert a malign influence on those vulnerable people for their own benefit, perhaps even for material benefit? What is done to protect those vulnerable people?

3.45 pm

Some espouse the view that there are those who would be better off dead or who are a burden to their loved ones or to the society in which they live and that time, energy and resources are being taken up in looking after them. In proposing the motion, my colleague Mr Donaldson mentioned Baroness Warnock, who has been forthright in her views on and support for assisted suicide. Of people who have dementia, she said:

"you're wasting people's lives — your family's lives — and you're wasting the resources of the National Health Service."

She went on to say:

"you'd be licensing people to put others down. Actually I think why not".

There is a view, which is espoused by such individuals as Baroness Warnock, that people are a burden when they get to old age or if they suffer from a particular illness. If we liberalise the law on this issue in any way, my greatest fear is that the people who are going through a difficult time in their lives and who need our help and assistance will be put at risk.

When I was preparing for today's debate, I was touched by the words of another member of the House of Lords, Baroness Campbell of Surbiton. She suffers from spinal muscular atrophy and is confined to a wheelchair. She has said that she could meet, in many ways, the criteria for assisted suicide that people are putting forward. She does not want to see the law changed to allow for assisted suicide, particularly for disabled people. She said:

"Our belief was that if the state were to sanction any person to assist another in the ending of that person's life, it would switch the mindset of doctors and those who would help us in this country to thinking that that is what we really want — the very people who need every encouragement to live and not to succumb to society's prevalent view that our situation is so tragic, so burdensome, so insufferable that surely we must want to die."

Those words are particularly poignant, coming as they do from somebody in Baroness Campbell's position.

Some Members said that, if assisted suicide were legalised, there would be safeguards in place. However, the evidence from other jurisdictions around the world that have entertained and played with the idea of allowing assisted suicide is that those safeguards will be absolutely worthless.

Jeffrey Donaldson cited the example of Holland, where 546 deaths in 2005 came about as a result of lethal drugs being prescribed but not at the request of the individuals who committed assisted suicide. In Oregon, in the United States, there are cases of "doctor-shopping". In 2008, 50% of cases of assisted suicide in that state involved individuals who had been with their doctor for less than eight weeks. Therefore, people are finding doctors who are sympathetic to the idea of assisted suicide and who know nothing of the patient's circumstances, illness or condition.

There are also famous cases concerning the Dignitas clinic in Switzerland. Although we see that clinic in the headlines, a lot of people do not realise that that clinic is under investigation on several counts, including accusations of malpractice, of profiteering from death and, dangerously, of assisting a depressed man to kill himself. The evidence from around the world is not, as one Member said, that such cases will be rare. Many ongoing cases have possible malpractice and wrongdoing connected with them.

We are a civilised, caring, compassionate and, above all, Christian society, and, when looking after those who are ill or the most vulnerable, those qualities should be

demonstrated. That should be what marks us out as a civilised, caring, compassionate and Christian society. We have some of the highest standards of palliative care in the world, and I echo the calls of others to see what we can do to help the likes of the Northern Ireland Hospice, Marie Curie Cancer Care and Macmillan Cancer Support to enhance the work that they do and to help more people in those difficult times of their lives.

The widespread, almost universal, medical opposition to assisted suicide is something that we cannot ignore. Nor can we ignore the fact that not a single group that works with the terminally ill or the elderly supports the introduction of assisted suicide.

In conclusion, I will quote Baroness Campbell, who is an inspiration on the subject. In a debate in the House of Lords on the subject of assisted suicide she said:

"If I should ever seek death — there have been times when my progressive condition challenges me — I want a guarantee that you are there supporting my continued life and its value. The last thing that I want is for you to give up on me, especially when I need you most."

Those words are extremely poignant. All lives are valuable, and we should not do anything, inside or outside the Chamber, that devalues human life. Assisted suicide is not an easy way out. It should not be viewed by the House or by any other legislature as an easy option to deal with a difficult issue.

Question put and agreed to.

Resolved:

That this Assembly notes the verdict in the Purdy case and the decision by the Director of Public Prosecutions in Northern Ireland to issue guidance on assisted suicide; and states its opposition to any attempt to legalise assisted suicide.

For further information about the PPS,
please contact:

Head of Information
Belfast Chambers
93 Chichester Street
Belfast BT1 3JR

Tel: 02890 897100
Fax: 02890 897030
Textphone: 02890 897011
E-mail: info@ppsni.gsi.gov.uk
Website: www.ppsni.gov.uk

This document can be made available in a range of alternative formats. Requests for alternative formats should be made to the Head of Information (at the contact details above).

Published February 2010

PUBLIC PROSECUTION SERVICE

INTERNATIONAL ASSOCIATION OF PROSECUTORS

INVESTORS IN PEOPLE