
OUT OF THE SHADOWS:
Why legalising assisted dying is safer than the status quo
CAMPAIGN FOR DIGNITY IN DYING.

CONTENTS.

INTRODUCTION.

The Terminally Ill Adults (End of Life) Bill, introduced by Kim Leadbeater MP, and reintroduced by Lauren Edwards MP, would allow terminally ill adults in the last 6 months of their life who have mental capacity, the option of requesting an assisted death. The request would have to be approved by two independent doctors, and a panel made up of a social worker, a psychiatrist and a senior legal expert.

The debate around the bill has often rightly focused on safety. But that debate should always be rooted in the context of what is already happening, and will continue to happen, in the absence of an assisted dying law. That is what this report focuses on.

The findings are stark:

- Home Office data shows that only around 1 in 6 recorded cases of assisting suicide ever reach the Director of Public Prosecutions, with most cases dropped by police due to a lack of evidence rather than compassionate discretion.
- Evidence suggests doctors are already operating in a legal grey area to support their patients seeking an assisted death abroad, with no guidance or protection from their professional bodies.
- Data from the NHS shows that terminally ill people are taking their own lives while receiving specialist palliative care, but the extent of it is unknown.
- Where assisted dying is legal, those who choose an assisted death are not driven by lack of access to palliative care - in fact, those choosing it are disproportionately well-supported.

THE CHOICE FACED BY MPS AND PEERS IS A SIMPLE ONE: it is a choice between the status quo, with no oversight at all, and an assisted dying law, with oversight and regulation at its heart.

A NOTE ON LANGUAGE.

This report uses the term 'assisted dying' to describe the act of a terminally ill adult requesting and receiving assistance to end their life at a time of their choosing. Dignity in Dying rejects the term 'assisted/assisting suicide' as it is inaccurate and does not reflect the experiences of dying people and their families we have spoken to. However, 'assisting suicide'/'aiding suicide' is the terminology used in the Suicide Act 1961, and that is therefore reflected in the language used in Home Office crime data and in the Crown Prosecution Service's records. Similarly, when this report refers to terminally ill people taking their own lives in palliative care settings, it uses the clinical terminology used by the NHS Trusts that record data and patient safety reporting systems. This is not a reflection of how Dignity in Dying characterises those deaths.

THE BLANKET BAN ON ASSISTED DYING.

In England and Wales under the Suicide Act 1961 and in Northern Ireland under the Criminal Justice Act (Northern Ireland) 1966 it is a crime to encourage or assist suicide. This crime carries a maximum penalty of 14 years' imprisonment. If someone provides encouragement or assistance, that is a crime, even if the person ends their life overseas in a country where assisted dying is legal.

Following Debbie Purdy's landmark legal victory in 2009, the then Director of Public Prosecutions (DPP), Keir Starmer, had to clarify what factors are taken into account by the Crown Prosecution Service (CPS) when considering whether a prosecution for encouraging or assisting suicide is in the public interest.

The guidelines, published in 2010 and updated in 2014, list 22 factors that will influence the decision.[1] These factors make clear that prosecution is less likely when the person had reached a voluntary, clear, settled and informed decision to end their life and the person suspected of assisting them was wholly motivated by compassion. Prosecution is more likely if the person did not have mental capacity, if they were assisted by a healthcare professional responsible for their care, or if the person assisting had malicious motives.

The DPP's prosecution guidelines apply in England and Wales and have been replicated by the Public Prosecution Service for Northern Ireland.

There is no specific crime of assisting suicide in Scotland, but it is possible that helping a competent adult to die could lead to a prosecution for culpable homicide.

Debbie Purdy's landmark legal victory in 2009

A supposedly "stern face and kind heart".

Proponents of the status quo argue that the blanket ban strikes the right balance between protecting vulnerable people and giving dying people control over their deaths. If you are dying, and you have access to £15,000 (the average cost of having an assisted death abroad) and healthcare professionals willing to provide support and medical documentation – often in breach of both the law and their professional guidance – you can travel to organisations like Dignitas in Switzerland, to have an assisted death. Your loved ones can break the law to accompany you and may face investigations upon their return if the police become aware of their crime but are unlikely to be prosecuted if they were motivated by compassion.

The status quo has been praised by some opponents of law change for having a stern face but a kind heart, with the threat of prosecution acting as a deterrent, protecting vulnerable people. That there are so few prosecutions is something, according to opponents of law change, that we should celebrate.[2,3,4]

This defence of the status quo rests on the assumption that the law has meaningful oversight of what is actually happening when someone seeks an assisted death abroad. The data, however, tells a very different story.

WHAT THE DATA TELLS US: HOW PEOPLE ARE TAKING MATTERS INTO THEIR OWN HANDS.

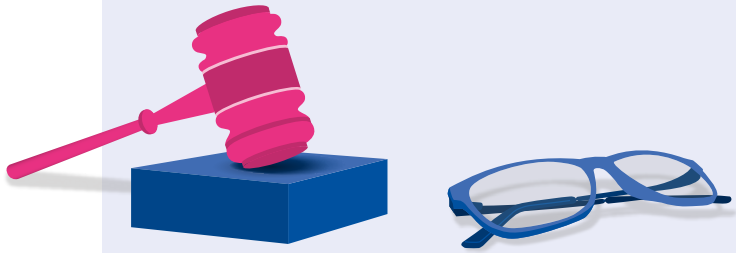
Assisted deaths abroad

ONLY AROUND 1 IN 6 CASES OF ASSISTED DYING REACH THE DESK OF THE DPP

The Home Office routinely publishes police crime data, which allows us to see the outcomes of different offences recorded by police forces across England and Wales. Dignity in Dying has analysed Home Office data on cases of assisting suicide over the past decade.

The data, taken as a whole, tell a story that is fundamentally at odds with the claim that the status quo provides meaningful protection to vulnerable people.

Since January 2015, the year when the House of Commons last had the opportunity to change the law on assisted dying with the Assisted Dying Bill introduced by Rob Marris MP, we know around 600 Britons have had an assisted death in Switzerland. Some of these people will have been from Scotland and Northern Ireland, but the vast majority are from England and Wales.[5] The exact figure of Brits having an assisted death in Switzerland itself is unknown and likely higher, given that there is no mandatory reporting mechanism and most organisations that provide assisted dying to Britons do not publish data.



LEGAL AND REGULATORY BLINDSPOTS

Since 2015:

600 Britons assisted to die in Switzerland

559 Cases of assisting suicide were recorded by the police

62% Cases dropped due to evidential difficulties

99 Cases referred to the CPS

From April 2015 to March 2026, 559 cases of assisting suicide in England and Wales[i] were recorded by the police. This is not limited only to cases of someone assisting someone else to access assisted dying overseas, though those cases should be included in this figure. The difference in the number of cases recorded by the police and the number of cases of Britons being assisted to die in Switzerland suggests that sometimes cases go completely undetected. It is possible that someone could access assisted dying in Switzerland without receiving any assistance, in which case it would not be recorded as a crime. However, given the medical documentation required and the difficulty of travelling, this is extremely unlikely.

i The offence used by the Home Office in their data is 'aiding suicide' which reflects the language of Section 2 of the Suicide Act 1961 prior to amendments in 2010. For consistency the remainder of this section refers to assisting suicide.

In July 2026, Dignity in Dying conducted an analysis of historic police recorded crime and outcomes open data tables, published by the Home Office.[6] This data shows that of the 559 recorded cases from April 2015 to March 2026 in England and Wales, the majority – 62% – were dropped by police because of evidential difficulties. In the past five years, this figure has risen to 66%. This means that in the majority of cases, the police were not able to gather sufficient information about the circumstances of the person's death to pass the evidential stage of the test that prosecutors must apply to justify a prosecution. **In other words, the DPP has not exercised compassionate discretion in the majority of cases – the investigations failed before reaching them. The DPP does not see most cases.**

In fact, only 99 cases of 'assisted suicide' were referred to the CPS in this same time period. This means that only around 1 in 6 cases in the past 11 years have reached the DPP's desk. In the majority of cases the police have been unable to gather sufficient evidence to make a prosecution possible, even if in theory something happened that might justify one, for example, if someone had been pressured or coerced into having an assisted death, or they lacked mental capacity. The apparent 'kind and understanding heart' of the law applies only to a small number of assisted deaths. In the majority of cases, police do not know what happened, in what circumstances, or whether the person being assisted was vulnerable. The law is, in effect, blindfolded.

The law doesn't have a kind heart – it is blindfolded

Catie Fenner's mother, Alison, was diagnosed with motor neurone disease in 2022 and had an assisted death at Dignitas a year later.

"My mum had the peaceful death she wanted, but it was horrendous for our family. We had to keep it secret even from our closest family. We didn't want anyone to stop mum from going, and we could have got into trouble for helping her. The secrecy didn't protect anyone involved - neither my mum nor my family. It just meant my mum spent her final weeks unable to say a proper goodbye to so many friends and family."

Catie holding a picture of her mum, Alison

For the small fraction of cases that do reach the DPP's desk, Sir Max Hill, former DPP, has described the weight of that responsibility, and questions the role of the DPP in making the current law safe.

"Of the 27 cases I personally, anxiously and carefully considered as Director of Public Prosecutions, there was only one in which a charge was appropriate. In the other 26 cases of families who had supported a terminally ill relative to Dignitas, or who had helped a loved one die at home, I concluded that they were entirely compassionate, reluctant acts borne out of love. One of the questions I ask now is whether it is right that in those cases the compassionate, loving, lifelong partner should have to remain under threat of prosecution for many months, if not years. ***I was trying to steer the right course between murder, assisted suicide, and cases where there should be no criminal charge at all.*** *That is one way of placing a heavy burden on a single public official.*

These figures now show that in all likelihood, as DPP I did not have sight of the vast majority of these kinds of cases. I may have only concluded that a prosecution would have been inappropriate in those too, but if police forces are unable to gather enough information about the circumstances of these deaths to pass the evidential stage and enable the DPP to make a decision about whether to exercise discretion, ***how can anyone seriously claim the current law is safe?***

What we have at present is haphazard scrutiny after someone has died. It would be more logical, safer and fairer to have a legal framework with upfront scrutiny and safeguards for those who wish to exercise choice at the end of life, which is what the Terminally Ill Adults (End of Life) Bill will create."

Sir Max Hill, Director of Public Prosecutions 2018-2023

There has been a 140% increase in the number of British members of Dignitas since 2015.[7] In this time new organisations have emerged that offer their services to citizens of other countries. The lack of oversight over how people travel from this country to another for an assisted death – and the potential harm that arises from this – is only likely to get worse over time unless Parliament acts.

The law is neither kind nor a deterrent. The status quo is dangerous, lacks upfront safeguards and fails to protect potentially vulnerable people.

LACK OF PROTECTION FOR DOCTORS.

Doctors in the UK are potentially illegally helping people have an assisted death

When it comes to having an assisted death abroad, the legal void is not only unclear for dying people, their loved ones, police and prosecutors, but also for healthcare professionals.

The General Medical Council (GMC) encourages doctors to listen to and discuss patient requests for assisted dying and has said that providing access to a patient's medical records knowing or suspecting they may be used to access an assisted death will not normally give rise to a question of impaired fitness to practise.[8,9] But many dying people seeking an assisted death abroad may require an additional medical report from their doctor which outlines their diagnosis and prognosis. On this issue, the GMC says "writing reports knowing, or having reasonable suspicion, that the reports will be used to enable the person to obtain encouragement or assistance in committing suicide" may raise a question of impaired fitness to practise.[10]

The British Medical Association (BMA) is explicit in its recommendation to members that they do not "write medical reports specifically to facilitate assisted suicide abroad", as it may constitute assisting or encouraging suicide.[11] The Medical and Dental Defence Union of Scotland (MDDUS), which provides expert medico-legal advice for healthcare professionals throughout the UK, reminds doctors of the GMC guidance, and that they should

"exercise care" when considering requests for medical reports or copies of medical records.[12] The Royal College of General Practitioners (RCGP), the Royal College of Physicians (RCP) and the Royal College of Psychiatrists (RCPsych) provide no information about what their members can and cannot do to support someone who is seeking an assisted death abroad.

We know that people who want to arrange an assisted death in Switzerland often do need a medical report from a doctor to get a "green light". The result is a situation in which some doctors provide the support their patients need, others refuse, with doctors' positions determined by a lack of clear support and guidance.

Dr Paul Teed, an emergency medicine speciality doctor, has researched how people are accessing assisted dying. His PhD, *Sneaking off to Switzerland*, explores the experiences of people trying to source the medical documentation required for an assisted dying application abroad.[13] The findings show that some doctors are actively supporting their patients with their application, seemingly going against professional and regulatory advice.

Sneaking off to Switzerland includes this report of a mental capacity assessment, sent to Dignitas by a consultant psychiatrist who is registered with the GMC and is a Fellow of the Royal College of Psychiatrists.

[redacted] 2018

Dignitas
PO Box 17
812 Forch
Switzerland

Dear Sirs

[redacted]

I write to confirm that [redacted] consulted me on [redacted] for an assessment of his mental state with particular reference to his capacity of judgement in respect of his wish to access your service of an accompanied suicide. I can confirm that I am a medical practitioner with specialist qualifications in the Assessment and Diagnosis of Mental Disorder and am on the Specialist Register of the General Medical Council. My expertise includes Assessment of Mental Capacity of Judgement.

[redacted] was accompanied by his wife throughout the consultation. He gave a detailed account of his life, both from the family and career perspectives as well as detailing his past medical history. In [redacted] and after neurological assessment and investigations was diagnosed with Motor neurone disease (amyotrophic lateral sclerosis) and given a prognosis of six - 24 months. He is currently under the care of [redacted] He estimated the benefits of these treatments to be modest at best.

The progression of Motor neurone disease is divided into three phases as follows:

Phase1: One can still do everything but a number of things are becoming progressively more difficult.

Phase 2: Some of the activities of daily living can no longer be done.

Phase 3: The 'death phase' in particular when respiratory muscles begin to weaken.

[redacted] estimated that he was entering phase 2 and gave a number of instances supporting this view i.e. he has had to give up [redacted] The weakness in both hands means he has trouble opening bottles and is requiring increasing assistance in putting on his jacket. He is

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otherwise still able to dress himself and use a computer and is able to walk. He gets much more tired than he previously did and now needs a sleep in the afternoons. The normal activities of daily living are all taking much longer than previously.

[redacted] has enjoyed good mental health throughout his life [redacted]

My assessment of [redacted] mental state revealed a euthymic mood in an individual who was fully cooperative and open throughout the interview. There was no evidence of disturbance of thinking either in terms of form or content and no psychotic phenomena such as hallucinations and passivity experiences were observed/elicited. He was fully oriented in time and place and his immediate recall and knowledge of recent events was excellent.

In terms of his mental capacity of judgement, we discussed at length his request to access the service of an accompanied suicide at Dignitas. He first approached you in early 2017 about your service. He and his wife have given this much thought since initially doing so and he has remained resolute in his view in applying for a provisional Green Light. He wishes to have the option to accelerate his death at a time of his choosing in order to avoid what is likely to be a very unpleasant, lingering death both for his own sake and for that of his family. In very practical terms he feels that it is a tremendous waste of resources providing carers and other support services in order to maintain a life that is devoid of any quality. He feels that being granted a provisional Green Light will allow him to focus on maximising the remaining quality time he has with his family rather than living in fear of what the future holds in terms of prolonged suffering and distress.

[redacted] is a highly intelligent individual who has a full understanding of the process involved in an accompanied suicide. He has read your website in detail along with the information you have sent to him. He demonstrated an ability to retain this information which is more than sufficient for him to make an informed judgement about the process and the outcome. It was very clear at interview that this decision was very much his own and had not been made under duress or influence from anyone else including his wife. She is obviously incredibly supportive of his decision but at the same time understandably distressed. In addition he has been very open with members of his family and close friends about his commitment to this decision. No one thought this to be in anyway irrational or ill-informed.

In summary I am of the very strong professional opinion that [redacted] does indeed have full mental capacity of judgement in respect of the specific decision to access your service of an accompanied suicide. Please accept this report in support of his request to obtain a provisional Green Light. Finally he is fully aware that up to 70 percent of people who are granted a Green Light do not proceed with an accompanied suicide.

If I can be of further assistance please do not hesitate to revert to me.

Yours faithfully

[redacted] **FRCPsych**
Consultant Psychiatrist

Mental capacity assessment sent to Dignitas by a GMC-registered consultant psychiatrist

Most professional bodies have adopted a neutral position on assisted dying in recent years, in order to represent the range of views of their members. Surveys by the British Medical Association and Royal Colleges have found a significant number of doctors would be prepared to support their patients with the option of assisted dying should it become legal.[14] While parliamentary debates have often focused on what professional medical bodies have to say about how a change in the law may affect their members, less attention has been given to the problems their members face at present. Evidently, some are risking their careers to support people who are seeking choice at the end of life in other countries, and in doing so they are acting without any adequate legal protection or sufficient professional guidance.

RECORDED SUICIDES IN PALLIATIVE CARE SETTINGS.

Dying people are taking their own lives while receiving specialist palliative care

The Home Office data shines a light on the limits of the law in protecting dying people who turn to other jurisdictions for help to hasten their deaths. The picture for terminally ill people who take matters into their own hands in this country is, if anything, worse.

In 2021, research by Dignity in Dying estimated that up to 650 dying people in the UK end their own lives every year. A further estimated 3,000-6,500 dying people attempt to end their lives every year.[15]

A number of sources of data were used to calculate this estimate. For example, in 2017, the Public Health and Social Research Unit at West Sussex County Council published an analysis of suicides and likely suicides recorded in West Sussex between 2013 and 2015. The researchers examined police reports, suicide notes, physical and mental health histories and copies of inquests. They found that in 10% of cases individuals were driven to end their own lives by a terminal illness and 'continuing decline in health, where they felt their standard of living had been significantly reduced' and it was believed they 'had chosen to end their life before their health deteriorated further.' [16]

Some have argued that as a society we should focus on improving the provision of specialist palliative care instead of debating assisted dying. This argument rests on the premise that if someone is receiving specialist palliative care it will eradicate their wish to have the choice of an assisted death. Data from other jurisdictions featured in the next section shows why that is not true. However, we know that in the absence of safe and regulated choice in the UK, many dying people do take their own lives, even while receiving specialist palliative care.

In an attempt to understand the extent of this harm, in April 2023 Dignity in Dying sent a Freedom of Information (FOI) request to NHS Trusts and Health Boards in England, Wales and Scotland requesting data on the number of suicides and suicide attempts recorded amongst patients receiving specialist palliative care, including in NHS specialist palliative care units between January 2017 and December 2022. In 2026, we repeated this FOI request, seeking data from January 2023 to December 2025. The compiled data highlights two things: that dying people are ending their own lives while receiving palliative care and that there is an unacceptable gap in how we monitor these deaths.

2026 FOI Request

In 2026, we sent FOI requests to 149 NHS Trusts and Health Boards across England, Wales and Scotland. 143 responded (96%). Of those that responded, only two-thirds of Trusts and Health Boards recorded or had access to data on the number of terminally ill people taking their own lives. This is marginally greater than the number that recorded data in the 2023 request.

Of those that recorded the information, 8% (8 out of 96 Trusts/Health Boards) had a record of at least one suicide or attempted suicide by a person receiving specialist palliative care between 2023 and 2025. The FOI in 2023 showed that 17% (16 out of 90 Trusts/Health Boards) had a record of at least one suicide or attempted suicide by a person receiving specialist palliative care between 2017 and 2022.[ii]

This data helps us understand the limits of specialist palliative care. There is a growing evidence-base and widespread acceptance around the inability of palliative care to relieve all suffering all of the time, including data that shows 20 people a day will die in unrelieved pain across the UK despite access to palliative care.[17] This data shows that there is a problem in this country of dying people ending their own lives even when they are in receipt of the very best available care.

What we do not know is who, how many, under what circumstances, and importantly, what support people have had, or not had, before making that decision.

We have no way of protecting people when they are left with no option but to make decisions behind closed doors.

For a third of NHS Trusts, we simply do not know how many dying people are taking, or making attempts to take, their own lives while receiving specialist palliative care. This data - or lack thereof - exposes the extent to which we lack oversight of how dying people are already trying to exercise control over how their lives end.

If the case for the status quo rests on the law protecting vulnerable people, including those who might feel that ending their own life is the only option available to them, then the absence of data on suicide among terminally ill people is a fundamental failure of that system; it is a compound harm of the status quo.

ii It is not possible to accurately combine results from both FOI requests to provide total figures recorded between 2017 and 2025, due in part to structural changes to the Trusts, such as mergers and disbandment. Additionally, some Trusts which recorded and provided data in 2023 responded in 2026 that they no longer collected the data or that its provision exceeded the statutory FOI expenses limit; or vice versa.

NHS Patient Safety FOI – Learn from Patient Safety Events

The Learn from Patient Safety Events (LFPSE) service was introduced by NHS England in 2021 for the recording and analysis of patient safety events that occur in healthcare settings. To learn more about terminally ill people taking their own lives, in 2026 Dignity in Dying sent an FOI request to NHS England to ask for the number of patient safety events recorded where the incident related to suicide/attempted suicide and the reporting organisation was a hospice or an NHS palliative care service.

The response to the FOI request showed:

- There were 59 cases recorded as incidents of 'self-harm'. This will likely include suicide/attempted suicide, as this is not separately categorised by LFPSE.
- NHS England cannot say how many incidents happened in hospices, as hospices report to their own Trust.
- There was no data available between 2021-2023 (reasons unknown).

We also asked NHS England to share anonymised details of the patient safety incidents, which they declined to do, citing risks around disclosing the details of "potentially alarming stories".

It is possible that there is double counting between the cases recorded by individual NHS Trusts and the LFPSE.

It is also worth noting that the results from both FOI requests do not allow us to know exact figures from hospices, though we know from the literature that – while rare – suicides in hospices do happen.[18,19] We would urge hospices to collect and publish data on these deaths.

The data that we do have access to, and the alarming lack of other data, show us that the pattern is consistent: the DPP does not know what happens in the majority of assisted dying cases abroad because the evidence never reaches them, and the NHS does not know the true scale of suicide among dying people because not all Trusts collect the data.

Simon, who has an incurable, progressive illness, describes the reality of the choice currently available to him.

Simon, photographed by Rankin

"I have 3 options: 1) Dignitas with all the difficulty that entails, 2) I could try to end my life myself using medication over the counter, or 3) I could try and source what I need on the dark web."

The effect that these desperate decisions have on people is far reaching. Vanessa Pilny, a palliative care doctor, describes a terminally ill man taking his own life in a hospice.

"I remember a man we were caring for in a hospice I worked at. He wanted to control how his life ended – to die on his own terms – but he knew we couldn't give him what he so desperately wanted. He was angry, but it wasn't an impulsive, emotional anger. When someone is at the very end of their life there are fewer and fewer decisions they are in a position to make, and those decisions become more and more important. Things take on such a deep meaning, and I think it's sometimes difficult for others to really understand that. Disempowering people in those moments and taking control away from them is a form of cruelty, but it can also feel like an abdication of our clinical responsibilities. If we aren't responding to people's needs, can we really claim to be caring for them?

After days of asking why he couldn't be given assistance to die in a peaceful way, at the time of his choosing, he made the only choice he felt he had left and ended his own life in a way that was traumatic and painful, not just for him but also for the other inpatients and their family members who witnessed the event.

I've seen firsthand the difference palliative care can make to people's lives, from pain and symptom relief to psychological support and even when all else fails we can try to sedate people. But that's not always enough. ***He had access to it all, but he wanted something else.*** *At the moment, we've drawn a line that says 'we're willing to give you this care, but we're not willing to let you have that'. I think we've drawn that line in the wrong place, and it's causing so much harm."*

WHO THE STATUS QUO FAILS: ASSISTED DYING AND INEQUALITY.

Assisted dying and inequality

IN PLACES WHERE ASSISTED DYING IS LEGAL, PEOPLE WHO ACCESS IT ARE NOT THOSE WHO EXPERIENCE INEQUALITIES IN PALLIATIVE CARE.

We do not know the full extent of how dying people are exercising choice in this country in the absence of safe and legal assisted dying, because the data simply is not collected and the status quo lacks sufficient mechanisms to monitor these deaths.

What's more, because the cost of travelling to Dignitas – or other facilities in Switzerland – is beyond the reach of most people, especially those living in poverty or deprivation, there is already an inequality inbuilt in the status quo. Yet the prohibitive cost is not the only inequality. The process of obtaining the necessary medical documentation and navigating a complex process while terminally ill also demands a level of health literacy and practical resource that many do not have. For communities with deep-rooted reasons to distrust the criminal justice system, the idea that prosecutors will treat bereaved family members with a 'kind heart' will likely carry little assurance.

The status quo does not protect these groups of people, it just leaves them with fewer options than others in society.

Keith who died of terminal lung cancer in 2026, spent his final weeks campaigning for a change in the law on assisted dying. He said:

Keith, photographed by Rankin, shortly before his death

"It is primarily the poor who are affected by this. People who have money are able to take themselves to a different country. Those who don't have loads of money suffer as a result of assisted dying not being legal."

Palliative care inequality in the UK

The UK has been recognised as having advanced palliative care.[20] However, that is not to say that people are able to access that palliative care equally. Hospice UK identifies people living in poverty and deprivation, racialised communities, people with learning disabilities, LGBTQ+ people, those experiencing homelessness, people in prison, those living with non-malignant conditions, and people in remote and rural areas as among those consistently excluded from receiving high-quality palliative and end-of-life care.[21]

Some have raised fears that these same groups, already less likely to access palliative care, would be disproportionately likely to access assisted dying if it were legal – even though both would be accessed through the same clinical routes.

Who accesses assisted dying where it is legal?

In every jurisdiction where assisted dying is legal, the vast majority of people are already receiving palliative care at the time of the request. The groups identified by Hospice UK as those least likely to receive equitable care are actually disproportionately less likely to access assisted dying where it is legal. In other words, the evidence does not show that assisted dying is driven by unequal access to end-of-life care. These patterns are consistent over multiple jurisdictions and over time.[22]

A five-year review into the operation of Victoria's assisted dying law adds an additional layer to this. The uptake of assisted dying in regional and rural Victoria was consistently higher than in metropolitan areas. 88% of rural and regional applicants were already receiving palliative care when they made their first request, compared with 83% of metropolitan applicants. The higher rate of assisted dying uptake in rural and regional areas does not reflect difficulty in accessing palliative care, it reflects people choosing assisted dying alongside palliative care.[23]

The groups identified by Hospice UK as those least likely to receive equitable care are not those who are accessing assisted dying where it is legal.

In other words, assisted dying is not driven by unequal access to end-of-life care.

Table shows demographic profile of people who accessed assisted dying

JURISDICTION	AGE	SEX	ETHNICITY	EDUCATION
Oregon, USA (1998-2023)	Aged 65 or over - 77%	Female 47% Male 53%	White 96% African American 0.2% American Indian 0.3% Asian 1.8%	Completed at least secondary 96%
California, USA (2016-2024)	Aged 70 or over - 71%	Female 49% (additional breakdown not specified)	White 87% Black 0.8% Hispanic 4% Asian 6%	Completed at least secondary 97%
Victoria, Aus (2019-2025)	Aged 70 or over - 60%	Female 46% Male 54%	Identify as Aboriginal 1% Do not identify as Aboriginal 95%	Completed at least secondary 55%
New South Wales, Aus (2024-2025)	Aged 70 or over - 70%	Female 46% Male 54%	Identify as Aboriginal 2.7% Do not identify as Aboriginal 95%	Completed at least secondary 65%
New Zealand (2024-2025)	Aged 65 or over - 79%	Female 49% Male 51%	Māori 5% European / Pākehā 80%	Does not record

JURISDICTION	GEOGRAPHIC DISTRIBUTION	ACCESSING PALLIATIVE CARE	PLACE OF DEATH
Oregon, USA (1998-2023)	Does not record	Yes 91% No 9%	Home 92% Assisted living or care facility 5% Hospital or hospice 0.7%
California, USA (2016-2024)	Does not record	Yes 92% No 7%	Home 89% Assisted living 6% Hospital or hospice 1.4%
Victoria, Aus (2019-2025)	Metropolitan Melbourne 63% Regional Victoria 37%	Yes 79% No 14%	Home 45% Hospital 49% Residential care facility 6%
New South Wales, Aus (2024-2025)	Greater Sydney 32% Regional 68%	Yes 85% No 13%	Does not record
New Zealand (2024-2025)	Does not record	Yes 78% No 21%	Private residence 65% Aged care facility 21% Hospice 4%

Inequality in assisted dying abroad

The data shows us that inequality is relevant to both palliative care and assisted dying, but in very different ways. Findings from the five-year review into the operation of Victoria's assisted dying law and the First Nations consultation found that Aboriginal and Torres Strait Islander communities were disproportionately less likely to access assisted dying, with a lack of culturally appropriate resources and information identified as a barrier to understanding and accessing assisted dying in Victoria.[24,25] The review also demonstrated low awareness of assisted dying among multicultural communities, which is consistent with other research in Victoria.[26] The Victorian government recognises this as a failure of the system and is working to increase awareness and accessibility among underserved communities, so that people are fully informed about their end-of-life rights.

This is what a regulated system makes possible: identifying which communities are being underserved, understanding the reasons why, and working on closing that gap. This is precisely what is unavailable in the UK – there is insufficient data to allow us to truly understand which communities are negatively impacted by the status quo.

We also know that assisted dying legislation has been a catalyst for increased funding of palliative care in other jurisdictions. A report by Centre Think Tank shows in Australia, states have invested almost one billion Australian dollars in additional funding since legislation was introduced.[27] The report states this funding has been used to address inequalities:

There was a particular focus on improving palliative care services in areas which are often underserved, for instance, areas without easy access to a hospice or rural areas where access was limited. The specific areas for additional funding included improving how palliative care is delivered, including telehealth, after-hours care, home care, hotline services, and the number of palliative care beds available.

We have already seen this take effect in this country. In November 2025, Stephen Kinnock MP, Minister of State at the Department of Health and Social Care, said that the Terminally Ill Adults (End of Life) Bill had been a "catalyst for the work [the Government is] doing in palliative and end-of-life care".[28] In February 2025, Toby Porter, the CEO of Hospice UK said, "I don't think the [recent] hospice funding would have materialised had the assisted dying debate not taken place when it did".[29]

Far from being a threat to palliative care which risks increasing inequalities, evidence shows that assisted dying legislation does not disproportionately impact different groups experiencing inequalities. In fact, by shining a spotlight on the importance of what it means for people to die well, on their own terms, it may help address some of the problems with inequalities and palliative care we see in the UK.

CONCLUSION.

The debate around the Terminally Ill Adults (End of Life) Bill has rightly prompted consideration of the safeguards in the proposed assisted dying law. However, this debate must be had in the context of the status quo.

This report shines a light on that. Investigations into how people are currently accessing assisted dying overseas from this country are conducted after the fact, if at all. The law provides little reassurance that it contains meaningful safeguards capable of protecting people. NHS Trusts, Health Boards and NHS England have records of terminally ill people attempting to take their own lives, but they do not routinely collect this data. Doctors help their patients without guidance in a legal and regulatory grey area that professional bodies have failed to acknowledge or address. Arguments around inequalities at the end of life are often used against a change in the law, yet evidence shows these are unfounded and distract from the injustices created by the blanket ban on assisted dying. The blanket ban on assisted dying does not protect or serve the best interests of potentially vulnerable people.

By contrast, the Terminally Ill Adults (End of Life) Bill would put in place clear, upfront protections, with defined roles for the medical and legal profession. This would provide a level of monitoring and oversight that is simply absent in the status quo. In every jurisdiction where assisted dying is legal, every assisted death is reported, documented, reviewed and published in an annual report. The demographics of those who access assistance are known. Involvement of palliative care is tracked and public so patterns can be seen. There are robust systems for reporting and investigating concerns and assisted dying services are continually being improved. Regulation introduces visibility and oversight into a system that currently has none.

A regulated assisted dying law, on its own, would not resolve the current inequality in palliative care. But the evidence from every jurisdiction where assisted dying is legal is clear: **it is not a substitute for good quality palliative care. Dying people want both.**

The choice MPs and Peers are facing is between the status quo, with no oversight at all, and a tried and tested assisted dying law, with oversight and regulation at its heart.

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