**THE HIGH COURT**

**[2012 No. 10589P]**

**Kearns P.**
**Carney J.**
**Hogan J.**
**BETWEEN**

**MARIE FLEMING**

**PLAINTIFF**

**AND**
**IRELAND, THE ATTORNEY GENERAL AND THE DIRECTOR OF PUBLIC PROSECUTIONS**

**DEFENDANTS**

**JUDGMENT of the Court delivered by Kearns P. on the 10th day of January, 2013**

**1.** In the 75 years since the Constitution was enacted both this Court and the Supreme Court have been required to examine a vast proliferation of issues in a huge corpus of case-law. Over that period few cases have emerged which are more tragic or which present more difficult or profound questions than the issues presented for adjudication here. At the heart of this application lie novel and difficult questions as to whether constitutional provisions which guarantee personal liberty and autonomy in Article 40 of the Constitution are interfered with by a statutory prohibition which prohibits even a citizen in deep personal distress and afflicted by a terminal and degenerative illness to avail of an assisted suicide and, if they do, whether such an absolute statutory prohibition passes a proportionality test.

**2.** These proceedings were commenced by plenary summons on 25th October, 2012 and were fast-tracked and case managed to full hearing before this Court on 5th December, 2012.

**3.** In the proceedings the plaintiff's claim is for:

> (1) An order declaring that section 2, subsection (2) of the Criminal Law (Suicide) Act 1993 is invalid having regard to the provisions of the Constitution of Ireland;
>
> (2) An order declaring that section 2, subsection (2) of the Criminal Law (Suicide) Act 1993 is incompatible with the rights of the plaintiff pursuant to the European Convention on Human Rights and Fundamental Freedoms;
>
> (3) In the alternative, an order directing the third named defendant, within such time as to this Court shall seem just and appropriate, to promulgate guidelines stating the factors that will be taken into account in deciding, pursuant to section 2, subsection (4) of the Criminal Law (Suicide) Act 1993, whether to prosecute or to consent to the prosecution of any particular person in circumstances such as those that will affect a person who assists the plaintiff in ending her life.

**4.** The Criminal Law (Suicide) Act 1993 (hereinafter referred to as "the Act") abolished the offence of suicide while providing for an offence for an accomplice to suicide. Section 2 of the Act provides:-

> "(1) Suicide shall cease to be a crime.
>
> (2) A person who aids, abets, counsels or procures the suicide of another, or an attempt by another to commit suicide, shall be guilty of an offence and shall be liable on conviction on indictment to imprisonment for a term not exceeding 14 years.
>
> (3) If, on the trial of an indictment for murder, murder to which s. 3 of the Criminal Justice Act 1999 applies or manslaughter, it is proved that the person charged aided, abetted, counselled or procured the suicide of the person alleged to have been killed, he may be found guilty of an offence under this section.
>
> (4) No proceedings shall be instituted for an offence under this section except by or with the consent of the Director of Public Prosecutions."

**5.** Defences to the plaintiff's various claims were filed on behalf of the State defendants and on behalf of the Director of Public Prosecutions.

**6.** The defence delivered on behalf of the State denies that the said statutory provision infringes any specific or unenumerated constitutional right enjoyed by the plaintiff in the manner pleaded and further denies that the Constitution of Ireland expressly or implicitly confers upon the plaintiff or any other person a right to die. The defence states that the said statutory provision is necessary in the interests of the common good and that the public interest in maintaining that statutory provision without qualification or exception outweighs any alleged rights which the plaintiff might claim to have in terms of obtaining the assistance of another person for the purpose of terminating her own life. The Criminal Law (Suicide) Act 1993 is a law of general application which is designed to cover the many circumstances in which one person might aid, abet, counsel or procure the suicide or attempted suicide of another and it is therefore necessary for the promotion of the common good and the protection of the public interest. The defence also contends that s. 2 (2) of the Criminal Law (Suicide) Act 1993 admits of no qualification or exception to the offence of aiding, abetting, counselling or procuring the suicide or assisted suicide of another. The statutory provision does not, however, exclude the application of any general defences available at common law.

**7.** It is further denied by these defendants that the statutory provision is incompatible with the State's obligations under the European Convention on Human Rights or any provision thereof. It is further denied that the plaintiff is entitled to seek a remedy directly from this Court on the basis of a claim that there has been an alleged breach of her rights by reference to the provisions of the European Convention on Human Rights. The European Convention on Human Rights Act 2003 does not give direct effect in Irish Law to the European Convention on Human Rights. Alternatively, it is denied that the statutory provision contravenes any right of the plaintiff defined under the Convention or that it discriminates against the plaintiff on the ground of disability contrary to Article 14 of the Convention.

**8.** The defence of the third named defendant denies that the common law provides no exception or defence in that any person charged with an offence under the section would have available any common law defences which arise generally in the case of

serious indictable crime. This defendant contends that the entitlement of the Director to exercise a discretion whether or not to prosecute arises only after the commission of an offence and that she is not obliged under the Constitution or at law to promulgate guidelines. This defendant further denies that her refusal so to do constitutes a breach of the plaintiff's right to privacy either under Article 40 of the Constitution or under Article 8 of the European Convention on Human Rights. It is further denied that the Convention rights articulated in the plaintiff's claim are directly applicable in this jurisdiction and pleads that the plaintiff is confined to such rights and remedies as arise under the European Convention on Human Rights Act, 2003.

**9.** On behalf of the Human Rights Commission it was submitted that a person has a right, flowing from their personal autonomy rights, to take their own life in "defined and extreme" circumstances. The Commission invited the Court to consider whether the absolute ban on assisted suicide under Irish law is justified having regard to the extent of interference with the personal rights of a terminally ill, disabled and mentally competent person such as the plaintiff. The Court was invited to consider if it could be achieved in less absolute terms. The existing ban could be replaced by legislation which would be a measured and proportionate reconciliation of the right to life, reflecting the sanctity of life but also taking into account personal rights of autonomy, privacy and equality rights.

**BACKGROUND FACTS**

**10.** The plaintiff is 59 years of age and lives in Arklow, Co. Wicklow with her partner, Tom Curran, with whom she has been in a long term relationship since 1995. She has two children aged 40 and 28 from previous marriages. The plaintiff was born and raised in Lifford, Co. Donegal and is the eldest of five siblings. In 1986, aged 32 her first episode of multiple sclerosis began and a diagnosis of MS was made in 1989 when she was aged 35. At the time of her diagnosis during the years 1987 – 1992 she was the assistant director of the Department of Adult Education in the University of Swansea. When her marriage broke up in 1992 she returned to Ireland where she did some consultancy work in University College, Dublin until 1995, when she had to cease working due to her illness.

**Diagnosis**

**11.** Multiple sclerosis is an immune-mediated inflammatory disease causing neurological deficits which follows a relapsing-remitting pattern. Sufferers initially experience short-term neurological deficits and for some patients the disease involves progressive neurological deterioration and eventually death. Although there are some medications that can modify the progress of the disease in its early stage, there are no drugs to treat the advanced stages and there is no cure.

**Plaintiff's current condition**

**12.** The plaintiff's current neurological condition is that she is unable to walk or to use her lower or upper limbs. Since 2001 the plaintiff has been confined to a wheelchair as a means of mobility, although she can no longer propel herself. She therefore requires to be pushed. She would be unable to control an electric wheelchair. She has no bladder control. Since 2010 has lost the use of her hands and is almost totally physically helpless and requires assistance with all aspects of her daily living.

**13.** While she remains able to communicate it is becoming increasingly difficult for her to speak and the nature of her speech has changed significantly. This is associated with the gradual loss of control of the muscles of the neck. She is very concerned that, in due course, she will lose the capacity to communicate verbally. In order to maintain her speech she attends speech therapy and undertakes the necessary exercises and treatments. She frequently chokes when swallowing liquids and can suffer choking episodes, even when not attempting to swallow. Such choking episodes are extremely exhausting, frightening and generally distressing. The eventual loss of the ability to swallow will put her at risk of aspiration and she will eventually become dependent on artificial feeding. She is now in the final stage of her disease and is experiencing a rapid deterioration of her condition.

**Pain**

**14.** She states that she suffers from significant and frequent pain from a number of sources which is intense and sometimes almost unbearable.

**15.** She suffers from neurological-type pain in her hips, legs, hands and the back of her head and non-neurological pain associated with muscle weakness or spasm from sitting for prolonged periods of time. She suffers significant head and neck pain, lower back pain and severe arm pain associated with the weakening of muscles in the limbs. In addition she suffers frequent spasms in her upper and lower limbs which are extremely painful and debilitating; the affected limb becomes rigid and requires gradual easing of the limb back to a relaxed position in order to ease the pain.

**16.** She is now required to wear special splinting gloves because of painful spasms in her hands and in order to prevent their occurrence. She also reports suffering burning sensations in her temples and stabbing pains in her eyes.

**Daily routine**

**17.** Her typical daily routine involves waking at 8.00am and being given her tablets. At 9.00am she is toileted, fed, washed and dressed with assistance. If she chooses to have a shower the process takes approximately 2 hours. Once the tasks are complete she spends the remainder of the day in a wheelchair. She is required to be repositioned three to four times each day as sitting in the wheelchair is uncomfortable and contributes to the pain she experiences. Her activities are limited to listening to the radio, looking at her garden and on occasion, dictating for short periods. The process of preparing for the end of the day commences at approximately 6.00pm and she is in bed from 7.00pm until the following morning.

**Medication**

**18.** The plaintiff reports taking maximal doses of analgesia that she can without becoming comatose or reaching a level beyond which it is difficult to function. Therefore, while it is possible to control the pain somewhat to do so any further would decrease what quality of life she has. In total she takes 22 tablets per day: antispasmodic tablets, tablets for bladder control, for pain relief and for constipation. This medication is for the management of her symptoms as no treatment can be administered for the purpose of treating her condition. There are side effects to the medication which include dry mouth, hot and cold flushes, heart palpitations, drowsiness, nausea and sleeplessness.

**EDSS (Expanded Disability Status Scale)**

**19.** On the EDSS (Expanded Disability Status Scale), which is a scale used to describe the progress of multiple sclerosis, her

consultant neurologist Professor Tubridy assessed hers as an 8.5 which means the patient is essentially restricted to bed much of the day with some effective use of arms and some self care functions. However the plaintiff feels she has deteriorated since Prof. Tubridy's assessment and is now at 9 at best on the EDSS and possibly a 9.5 (difficulty speaking and swallowing). The next point on the EDSS is 10, representing death from the disease. Her condition is in the terminal phase and ability to function continues to deteriorate until her body completely shuts down.

**Mental capacity**

**20.** The plaintiff has been assessed with a view to establishing her levels of competence and has been advised that she has no underlying mental illness that does or is likely to affect her decision-making capacity. The disease has not impaired her cognitive functions. She states that she now lives with little or no dignity. She did consider ending her life five years ago by travelling to Switzerland to avail of the services offered by Dignitas. On the wishes of her partner and on the realisation that Dignitas was located in an industrial estate she postponed her decision. She now claims that if she were able to end her life she would do so and regrets not doing so before she lost the use of her arms. The thought of enduring months without the ability to communicate in pain and isolation with full consciousness or being heavily sedated to the point of being barely conscious is horrifying to her.

**21.** All of these facts are corroborated and confirmed in medical reports furnished as agreed evidence by the plaintiff's advisors, including those of Prof. Niall Tubridy, consultant neurologist, Dr. Paul Scully, consultant psychiatrist, Dr. Niall Pender, clinical neuropsychologist and her general practitioner, Dr. Ann Marie O'Farrell. Dr. O'Farrell's report, filed in the aftermath of the plaintiff's own evidence, stated that any decision by the plaintiff to withdraw consent to medical treatment and opt instead for palliative treatment only would not help her in any way because it would only exacerbate the worst features of her condition and require the re-instatement of her existing medication regime. The report also stated that the plaintiff's mind and its forceful clarity "is all that Marie has left". Both the plaintiff and Dr. O'Farrell believe that the side-effects of heavy pain-killing medication would significantly increase her drowsiness and reduce her clarity of thought. Dr. O'Farrell states that the plaintiff's strong wish is to preserve this mental clarity as it constitutes her one remaining faculty.

**ORAL EVIDENCE GIVEN TO THE COURT**

**Marie Fleming**

**22.** The Court was both humbled and inspired by the courage and mental clarity demonstrated by the plaintiff in coming to Court and giving evidence. She described in evidence how she had seven different carers and struggled every single day with the myriad problems outlined above. It left her feeling totally undignified. She had great difficulty trying to keep her head up and has constant pain in her shoulders, limbs and joints. She felt, indeed she was well aware, that her condition was getting worse but her medication for pain relief was presently at the top dosage she could take without becoming comatosed. She is presently taking 22 tablets of different medications every day. Her wish and her request to the Court was for assistance in having a peaceful dignified death in the arms of her partner and with her children in attendance. However, she did not wish to leave a legacy behind her whereby her partner or her children could be prosecuted. Her partner, while willing to help her, would only do so if it was lawful. She did not wish to die in the same way as a fellow sufferer from MS who died of hunger and thirst at the end of her treatment. She believed that with assistance she could self administer gas through a face mask. Alternatively with medical assistance a cannula could be put into her arm whereby a lethal injection would pass into her veins.

**23.** She told the Court she had confronted any fears she ever had about dying and was at peace with the world. She had even organised her funeral arrangements so as to include a wicker coffin and an accompaniment of jazz music on the day.

**24.** She stated she had nothing to hide and if an independent person needed to validate any steps that were taken she would be quite happy with that. She confirmed that palliative care was not acceptable to her. Massive doses of painkillers might alleviate the symptoms of pain but she believed it would keep her in a comatose state which she did not want.

**Professor Margaret Pabst Battin**

**25.** Professor Battin is a professor of philosophy at the Philosophy Department of the University of Utah in the United States. Her specialty is bioethics which incorporates medical ethics. Though not a clinician she has been studying the issue of assisted suicide for 30 years. In 2007 she co-authored a study on legal physical-assisted dying in the state of Oregon and the Netherlands. This 2007 study concluded that there was not a disproportionate impact on vulnerable persons where assisted dying was legalised. In 2008 she published a paper identifying and addressing objections made to the initial study.

**26.** Professor Battin commenced by saying that from her analysis of the Death with Dignity Act in Oregon and roughly analogous legislation in the Netherlands, sufficient safeguards in relation to assisted dying were in place to ensure abuse did not occur. (She suggested that there could be added safeguards such as antecedent consultation with the DPP). She identified two forms of abuse – procedural and substantive – and it was acknowledged that the possibility of abuse existed but there was no evidence of wholescale abuse.

**27.** In the 2007 study, ten vulnerable groups were identified which included the elderly, women, people without insurance, people with stigmatised illnesses, the poor, people with low educational status and those with disabilities. The fact that these groups were categorised by reference to certain socio-economic groups instead of by reference to emotional vulnerability or personality type was criticised in a paper by Finlay and George. Professor Battin responded that the study was looking for identifiable objective indicators not at the motivation or the particular mechanics of peoples' choices. She acknowledged that Finlay and George's understanding of what counts as "vulnerable" was different from that in the study. She continued that her data was robust and she was confident of the conclusions regarding these vulnerable groups since these categories were drawn from statements originating from various expert bodies such as the American College of Physicians and the British Medical Association.

**28.** She stated that the assumption that legalisation brings extra-legal practices into being is backwards, and its actual effect is to bring these practices out into the open and allow them to be regulated and controlled much more carefully. Citing the Netherlands she claimed that as legalisation becomes more robust, life-ending acts without current explicit request have been consistently declining.

**29.** Further, she said that not every request for assisted suicide is acted on and that assisted dying has not been extended to an ever widening circle. Overall, incidents of assisted dying are extremely low. In Oregon only 0.2% of people who die avail of this option. In the Netherlands the proportion is also small – about 3% of those who die. She stated that the vast majority of people do not die by assisted suicide. In relation to any issue of coercion she said this could be detected by a number of techniques such as conducting interviews with patients, family members, or physicians. The study avoided conjecture as to why people chose this route

and she went on to say that the 2007 paper was not saying that coercion could not conceivably occur but rather that it could serve as an index as to whether coercion did occur.

**30.** It was put to the witness in cross-examination that, by their nature, some of the feared abuses in relation to assisted dying, such as coercion, do not lend themselves to identification by empirical data. Professor Battin responded by saying that there are techniques for identifying coercion, therefore it is not impossible to detect. She went on to say that the 2007 paper was not saying that coercion could not conceivably occur. However, if there was coercion of the elderly then one would see higher rates and nothing was found that could be construed as evidence of coercion against a particular group of persons. The study explicitly declined to explore the issue of motivation.

**31.** Counsel for the State, Mr. Cush S.C., then put to her for her comment some eight objections in relation to her study. Most of the objections were discussed in order to highlight the fact that there were objections and not to examine their robustness. Objection 6, that the data cannot get at cases of depression, was recognised by Professor Battin as the most serious concern but she stated that it did not undermine the study as the data indicates euthanasia is not practised more frequently on people made vulnerable by mental illness. She also explained that there are many kinds of depression. The State pointed out that she herself called her claim "modest". The State then turned to the paper by Finlay and George where they cited Professor Linda Ganzini (who co-authored with her the 2007 paper) as saying that Oregon's Death with Dignity Act may not adequately protect all mentally ill patients. Professor Battin pointed out that Ganzini had used the phrase "may not" instead of "does not". The State responded by referring to Professor Ganzini and her conclusion that further study was needed to determine whether treatment for depression affected the choice to opt for assisted dying.

**32.** Objection 7 (that there is a misconstrual of "vulnerable patients), was said by Professor Battin to ring true to a certain extent. The key criticism from Finlay and George was that categories of vulnerability were drawn by reference to certain socio-economic groups instead of in relation to emotional vulnerability or personality type. Professor Battin responded that the study was looking for identifiable objective indicators and not at the motivation or the particular mechanics of peoples' choices. She acknowledged that Finlay and George's understanding of what counts as "vulnerable" was different from that in her study.

**33.** On the question of whether a change in legalisation would result in the abuse of vulnerable persons, two forms of abuse were identified – procedural and substantive – and it was acknowledged that the possibility of abuse existed but there was no evidence of wholescale abuse. She added that where there is procedural abuse it is declining and she was not aware of substantive abuse cases.

**Dr. Tony O'Brien**

**34.** Dr. Tony O'Brien is a consultant physician in palliative medicine and former chair of the Council of Europe Expert Committee on Palliative Care. He has 26 years experience with 30,000 dying or suffering patients and is one of Ireland's leading palliative care specialists. He told the Court that he supports the ban on assisted suicide and takes great comfort and reassurance from the fact that the law, as it stands, is explicit and abundantly clear. He is fearful that a change in the law would result in people opting for assisted suicide in the belief that they are an excessive burden to those around them. He added that were the law to change the whole issue of persons with impaired competence would be enormously difficult and the situation would be quite impossible. He stated that it would be "entirely radical for a physician to attempt to kill the pain by killing the patient."

**35.** He explained that palliative care is regarded as a medical intervention which is concerned with quality of life. It involves pain and symptom management where the patient is also given psychological, social, emotional and spiritual support so that they can live a life of their choosing in the place where they choose to live it to the greatest possible extent.

**36.** He stated that the representation that palliative medicine achieves pain control by effectively anaesthetising the patient is an incorrect one. He commented that opioids have the potential to offer enormous benefit that is not in any sense achieved by rendering the patient comatose or in any way compromised. Patients may function absolutely normally without restriction or impairment of cognitive functions provided that the drug dose is carefully selected, titrated and monitored. He explained that pain is the natural antagonist to opioid side effects. So if a person is in pain and taking an opioid, the pain will antagonise, not all, but many of the unwanted adverse effects of the opioids. Pain control is not the primary objective of palliative care. He found it to be an interesting feature from the experience of other jurisdictions that "uncontrolled pain typically ranks quite low down in the hierarchy when people are identifying reasons why they wish to have their life ended". A situation whereby a patient achieves and maintains an optimal level of pain and symptom control is the foundation stone on which the patient can build or rebuild the rest of their life. Dr. O'Brien stated that the use of opioids has a dual function: firstly, it achieves and maintains reasonable pain control; and secondly, it enables the patient live the life they choose to live.

**37.** He said Professor Battin's view of terminal sedation, involving necessarily the withdrawal of food and hydration, was inconsistent with his experience of the practice of sedation in this jurisdiction. He stated that sedation does not hasten death. He commented that patients are going to die with or without palliative sedation; they are dying as a direct, unavoidable and inevitable consequence of their underlying disease process. Moreover, he said that hydration and nutrition are entirely separate entities; one would have to weigh up the benefit/burden of each intervention. The benefit/burden of each treatment is undertaken individually and on an ongoing basis.

**38.** He stated that patients will die much more peacefully and in much less distress if their symptoms and fears are appropriately managed through palliative care. The level of sedative medication is carefully titrated to ease the patient's distress but is not administered in such doses whereby the clear intention is to shorten a person's life. On cross examination he rejected the assertion that sedatives are never administered as a primary purpose of shortening life but it is sometimes done knowing that that is what will happen.

**39.** According to Dr. O'Brien palliative care can assist in allowing the plaintiff to die in her own bed, in her own home and surrounded by her family. It can afford her the possibility of dying with dignity in a peaceful and gentle way. When death is expected within quite a short period of time the Irish Hospice Foundation will fund a nurse to attend to that patient overnight for a period of up to 14 nights. This is designed to give an additional layer of support, comfort and reassurance to family members and to others assisting in the care of such a person at home.

**40.** Dr. O'Brien said that the situation of the plaintiff could be greatly enhanced and significantly improved by active engagement with palliative care professionals. And there may be situations where palliative care professionals could reasonably reassure her in respect of her fears which he feels could be exaggerated or ill-founded.

**41.** According to Dr. O'Brien the idea that the plaintiff would become unable to communicate but would nevertheless remain conscious

would not be a likely occurrence as she would most likely succumb to respiratory sepsis. The risk of speech function being lost while swallowing and respiratory functions continue is unlikely as typically they decline roughly in parallel. Further, where patients lose the ability to speak that there are other ways in which they can communicate their needs very efficiently and effectively.

**Professor Robert George**

**42.** Prof. George is currently a consultant physician in Guy's and St. Thomas' hospital in London and is Professor of Palliative Care at Cicely Saunders Institute. He has been a consultant in palliative care since 1987. He said that deliberate intervention in the process of dying completely reclassifies the role of medicine. He claimed that distinguishing assistance from suicide would have an effect on the ambient view as to what is normal resulting in a paradigm shift in society. He described killing people as a treatment or as a solution as the greatest risk because it changes society fundamentally and that legalisation will result in a much more hazardous environment for the vulnerable. Using the example of the Netherlands, he commented that what began as voluntary euthanasia became non-voluntary for people who were incapable. The issue then affected people with psychiatric disorders and presently the possibility of offering it to children is being discussed. He also warned that once assisted suicide enters the domain of treatment then economic utility is considered. He cited a case from the Remmelink Report in which a patient had non-voluntary euthanasia in order to free up a hospital bed.

**43.** On the issue of safeguards he said that when they are incorporated into physician-assisted suicide they probably decrease but do not prevent its misapplication. He went on to say that it is difficult to objectively analyse a patient's capacity; depression and helplessness greatly impact on a patient's perception of their value and their desire for death. He also explained that many patients have a degree of mental incapacity as they are acutely ill; their capacity is affected by their symptomatology. Furthermore, in his experience patients change their minds all the time according to what is occurring with them clinically and psychologically within the dynamics of the family. He is not concerned primarily about malicious abuse but rather subconscious abuse. Legalisation will result in an ambient change in society where inherently groups of people are going to be at risk. According to Professor George if legalisation were to occur the likelihood of involuntary deaths would be "absolutely probable" and that the risks to vulnerable people are evident and cannot be monitored adequately.

**44.** On cross examination he said the narrow exception requested by the patient would not be less of a worry as no matter how narrow the argument is construed, it is a paradigm shift. He explained this by saying that "if there is one person who is considered legitimate or justified in making a claim then the territory changes by the very fact of the acceptance of that claim." In sum, allowing for the narrow exception that the plaintiff is requesting would lead to a "categorical change". He described the situation in Oregon where assisted suicide was narrowly defined and tightly controlled. He said that in the first year 15% of patients said being a burden on their family was a contributing factor in their decision to opt for assisted suicide. By year seven that figure rose to 32% and the median figure runs at around 42%. The legalisation in Oregon he said has lead to an ambient change and he is deeply troubled by that.

**45.** Professor George agreed with Dr. O'Brien that if the plaintiff were to re-engage with palliative care services it would benefit her greatly. He also stated that if someone has limitations in communication there are lots of means that one can use to improve the situation. He added that the earlier referrals to palliative care had lower sets of problems and their ability to resolve problems increased. This he explained was because the measures and the means to communicate were set in process to deal with deteriorating communication early and this allowed physicians to continue the processes despite the loss of function.

**46.** He went on to say that "if a person is able and decides to go and do whatever that person decides to do, then society may say they are free to do that, but if physicians are furnishing the means for somebody to do this then we are reclassifying a decision here." He commented that in terms of professional clinical practice in the UK a GP or other medical practitioner is under an active duty to stop that person possibly committing suicide.

**47.** Finally, he concurred with Dr. O'Brien on the correct use of opioids and said that the notion that "by giving opioids at the very end of life we are bringing about death simply isn't true in our experience and the evidence doesn't support it at all."

**THE CONSTITUTIONAL ISSUE**

**48.** The Court turns now to consider first the challenge to the constitutionality of the assisted suicide ban contained in s. 2 of the 1993 Act. It is only in the event that this constitutional challenge were to fail that this Court would have jurisdiction – should the matter arise - to issue a declaration of incompatibility under s. 5(1) of the European Convention of Human Rights Act 2003 ("the Act of 2003").

**49.** At the heart of the plaintiff's case is her contention that inasmuch as Article 40.3.2 of the Constitution protects her "person", this also necessarily embraces decisions concerning her personal welfare, including medical treatment. It is, of course, perfectly clear that the protection of personal autonomy in matters of this kind is a core constitutional value. The protection of the person is accordingly juxtaposed with other rights which are key to the fundamental freedom of the individual – liberty, good name and the protection of property. To this may be added the Preamble's commitment to the dignity and freedom of the individual as a fundamental constitutional objective and the recognition by Article 44.1 of freedom of individual conscience. For good measure, one might here also include similar and over-lapping rights such as the right to bodily integrity and personal privacy which have been judicially held to be protected as implied personal rights for the purposes of Article 40.3.1.

**50.** All of this means that the State cannot prescribe an orthodoxy in respect of life choices of this fundamental nature and, moreover, that individual choices of this kind taken by competent adults must normally be respected absent compelling reasons to the contrary. The following passage from the (admittedly dissenting) judgment of Henchy J. in *Norris v. Attorney Genera*l [1984] I.R. 36, 71-72 may be taken to represent the current judicial consensus on this question:

> "…there is necessarily given to the citizen, within the required social, political and moral framework, such a range of personal freedoms or immunities as are necessary to ensure his dignity and freedom as an individual in the type of society envisaged. The essence of those rights is that they inhere in the individual personality of the citizen in his capacity as a vital human component of the social, political and moral order posited by the Constitution….It is sufficient to say that there are [personal rights of this nature] which fall within a secluded area of activity or non-activity which may be claimed as necessary for the expression of individual personality, for purposes not always necessarily moral or commendable, but meriting recognition in circumstances which do not engender considerations such as State security, public order or morality, or other essential components of the common good."

**51.** In line with the sentiments expressed in this passage, the Court would observe that there are profound and different moral,

ethical, philosophical and religious views on the question of end-of-life decisions such as the issue in controversy here. These are questions which are best left to public discourse and political debate and do not in and of themselves directly impinge on our analysis. If, accordingly, the plaintiff's constitutional rights extend as far as the manner claimed, then the fact that she is exercising those rights in a manner and for a purpose which some might consider contrary to their own ethical, moral or religious beliefs – or even the prevailing *mores* of the majority - is irrelevant.

**52.** Inasmuch, therefore, as the plaintiff advances a conscientious and considered decision to seek the assistance of others to take active steps to end her own life in the face of a terminal illness which has ravaged her body and rendered her life one of almost complete misery, we consider that such a decision is *in principle* engaged by the right to personal autonomy which lies at the core of the protection of the person by Article 40.3.2. In that respect, therefore, such a decision is not really properly to be regarded as either an implied constitutional right in its own right or a right derived from an implied constitutional right in the manner discussed (and rejected) by the US Supreme Court in *Washington v. Glucksberg* 521 U.S. 207 (1997): it is rather a facet of that personal autonomy which is necessarily protected by the express words of Article 40.3.2 with regard to the protection of the person.

**53.** The Court, however, has chosen the words "in principle" advisedly, because it considers that there are here powerful countervailing considerations which fully justify the Oireachtas in enacting legislation such as the 1993 Act which makes the assistance of suicide a criminal offence. Like Rehnquist C.J. in *Glucksberg*, the Court believes there is a real and defining difference between a competent adult patient making the decision not to continue medical treatment on the one hand – even if death is the natural, imminent and foreseeable consequence of that decision - and the taking of *active steps* by *another* to bring about the end of that life of the other. The former generally involves the passive acceptance of the natural process of dying, a fate that will ultimately confront us all, whereas the latter involves the *active* ending of the life of *another* - a totally different matter.

**54.** This fundamental distinction further reflects the fact that one necessary feature of the Constitution's protection of the "person" in Article 40.3.2 is that the competent adult cannot be *compelled* to accept medical treatment and that our constitutional traditions have firmly set their face against the compulsion of the competent adult in matters of this kind: see, *e.g.*, *North Western Health Board v. H.W.* [2001] 3 I.R. 622, 746-753 *per* Hardiman J. and *Fitzpatrick v. FK* [2008] IEHC 104, [2009] 2 I.R. 7, 18-19, *per* Laffoy J. This, after all, is the rationale for the decision in *In re a Ward of Court (No.2)*[1996] 2 I.R 79, where a majority of the Supreme Court concluded that inasmuch as every competent adult could take steps to hasten their end by refusing medical treatment, that right should not be denied to the ward - who was not herself in a position to make such a judgment - if it were in her best interests to do so. It followed, therefore, that the courts were entitled to make that decision in the best interests of the ward. As it happens, that approach coincides in substantial measure with the view expressed by the US Supreme Court in a case with not dissimilar facts, *Cruzan v. Director, Missouri Department of Health* 497 U.S. 261 (1990), save that the U.S. courts would not compel a State to follow the wishes of the family in the absence of clear evidence as to what the patient herself would have wished.

**55.** The taking of active steps by a third party to bring about death is an entirely different matter, even if this is desired and wished for by an otherwise competent adult who sincerely and conscientiously desires this outcome and even if again, as Rehnquist C.J. observed in *Glucksberg*, the difference in some particular cases between the two types of decisions may sometimes be nuanced and blurred. *If* this Court could be satisfied that it would be possible to tailor-make a solution which would address the needs of Ms. Fleming *alone* without any *possible* implications for third parties or society at large, there might be a good deal to be said in favour of her case. But this Court cannot be so satisfied. It certainly can not devise some form of legislative solution which would be an impermissible function for the Court. Further, the Court is mindful that any legislative solution would have to be of *general* application and this is true *a fortiori* of any judicial decision which the Court might be called upon to make.

**56.** It may be possible for the Oireachtas to conceive of a solution to the acute personal and ethical dilemmas presented by this and other similar cases which would provide for extensive safeguards of the kind said to be found in the regulatory regime prevailing in jurisdictions such as Switzerland, the Netherlands and certain US states such as Washington and Oregon which have liberalised the law in this area. Those who contend for change – nearly all of them prompted by a sincere and humanitarian concern to minimise human suffering and distress at the end of life – maintain that it would be possible to put in place a range of essential legal safeguards. These might include a requirement that the patient is terminally ill; that he or she is facing intolerable pain; that the patient has been examined by a range of physicians over a period of time and has been appropriately counselled; that steps are taken to ensure that the patient is competent and not suffering from depression; that the patient has a settled will to bring about his or her end in this fashion and that the proposed course of action is reported to the appropriate authorities.

**57.** But even if it is allowed that these are precisely the safeguards which would be put in place in any applicable jurisdiction where the law was so liberalised, serious objections and concerns remain. As Professor George pointed out both in his witness statement and oral evidence, cases of wrongful diagnosis of terminal illness are not unknown. Thus, when a Select Committee of the House of Lords set about examining the Assisted Dying for the Terminally Ill Bill, they were told by the Royal College of Pathologists in 2004 that:

> "…post-mortem research and clinical audit studies performed in the UK, Europe, USA and many other countries consistently show about a 30% error rate in the medically certified cause of death [and that] significant error (i.e., misdiagnosis of the terminal illness resulting in inappropriate treatment) occurs in about 5% of cases."

**58.** If the law were so liberalised, there would accordingly be the attendant risk that some patients who were so wrongly diagnosed might elect to opt for physician assisted suicide rather than endure the debilitating terminal illness which clinicians had, in fact, wrongly diagnosed.

**59.** Even if it is also allowed that cases of this nature would be exceptional or, at least, unusual, the fact remains that it is impossible to predict with accuracy the duration and course of a terminal illness. A patient who is told by his or her clinician that his or her demise was measured in weeks might well have a different view of physician assisted suicide if it were ultimately to transpire that he or she could live for another year or more.

**60.** Then it is said that physician assisted death should be permitted in those cases where the pain is intolerable. The Court is, of course, completely mindful of the intense suffering that sometimes attends the dying and we sympathise to the greatest extent possible with Ms. Fleming's harrowing plight. The fact remains, however, that the definition of what pain is intolerable may vary from person to person and does not easily lend itself to objective assessment. In this context the Court is particularly mindful of the evidence given by Dr. O'Brien to the effect that pain, even when severe, ranks quite low in the motivational hierarchy for those seeking assisted suicide.

**61.** It is true that there have been surveys of the assisted suicides conducted under the liberalised regimes (Battin *et al.*, "Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patient in 'vulnerable' groups", *Journal of Medical Ethics* (2007) 33: 591-7) which reject the suggestion that potentially vulnerable groups (such as the poor, elderly, the

disabled, racial minorities, women and persons with low educational attainment) are in fact vulnerable to pressure. That may well be so, but the relevance of the selection of some of these particular groups in the context of physician assisted suicide may be questioned, as "socioeconomic categories are not necessarily a proxy for vulnerability to accessing [physician assisted suicide]": see Finlay and George, "Legal physician-assisted suicide in Oregon and the Netherlands: evidence concerning the impact on patients in vulnerable groups – another perspective on Oregon's data" *Journal of Medical Ethics* (2010) doi. 10.1136.

**62.** The Court, moreover, cannot overlook the fact that one of the co-authors of the 2007 study, Professor Linda Ganzini, has herself expressed concerns about the absence of appropriate safeguards in the Oregon law. That legislation requires that where the treating doctor has doubts regarding the mental capacity or suspects that a judgment-impairing depression might be present, a referral must be made for specialist psychiatric evaluation. Professor George gave evidence to the effect that in the latest report for 2011 from the Oregon Department of Public Health shows that for those who ended their lives by physician assisted suicide the referral rate for that year was just 1.4%.

**63.** Yet Professor Ganzini found in her study (Ganzini *et al*., "Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey", *British Medical Journal* 2008: 337: a1682) that of an (admittedly different and admittedly small) sample of some eighteen persons who had died in Oregon by ingesting legally supplied lethal drugs, three of them had been suffering from clinical depression which had not been detected by either assessing physicians or which had not been the subject of independent psychiatric examination. This led Professor Ganzini to observe that "in some cases depression is missed or overlooked" and she concluded that:

> "Our study suggests that most patients who request aid in dying do not have a depressive disorder. However, the current practice of the Death with Dignity Act in Oregon may not adequately protect all mentally ill patients, and increased vigilance and systematic examination for depression among patients who may access legalised aid in dying are needed."

**64.** Just as importantly, the 2007 study does not directly address the concerns which were powerfully expressed by the two expert witnesses led by the State, Dr. O'Brien and Professor George. They expressed deep concerns in respect of potentially vulnerable groups, but they also voiced the altogether more fundamental concern – which was not directly addressed in the 2007 study - that under a relaxed regime certain categories of patients with no visible signs of depression or other mental health issues and who did not belong to any of the traditional categories of vulnerable groups would place *themselves* under pressure to hasten their death in this fashion in a subtle manner that might often elude detection.

**65.** Thus, Dr. O'Brien stated that he saw:

> "….on a regular basis, individuals within families who suppress and ignore their own glaring health care needs in order to avoid difficulty or burden to those around them. And there is an enormous concern that were the law to change in this regard that such persons might seek [physician assisted suicide] not because of any view they have formed for their own benefit, but rather to ease the burden, emotional, practical, financial on those they care about."

**66.** Professor George drew attention to these risks in both direct testimony and in his witness statement:

> "It is, I suggest, important to be clear about the risks emanating from legalisation of these practices. The application of overt pressure on individuals to seek to end their own lives is likely to be uncommon – though it would be foolish to deny that it exists or that its presence can easily be detected. Much more common are the signals that relatives and others can send, albeit unconsciously, to a seriously-ill family member that he or she is become a burden on the family or that family life is being disrupted by the illness. There is such a thing as care fatigue and as a clinician treating patients in the final stages of their lives I have come across it in the most loving family environments. It is easy in such circumstances for seriously ill people to feel a sense of obligation to remove themselves from the scene."

**67.** Of the evidence given in this case, the Court prefers that offered by the State. The predominant thrust of the expert evidence offered by Dr. O'Brien and Professor George to the effect that relaxing the ban on assisted suicide would bring about a paradigm shift with unforeseeable (and perhaps uncontrollable) changes in attitude and behaviour to assisted suicide struck the Court as compelling and deeply worrying. The Court was particularly impressed by the evidence given by these two witnesses based as they are on many years of clinical experience in dealing with and treating terminally ill patients. The Court finds the evidence of these witnesses, whether taken together or separately, more convincing than that tendered by Professor Battin, not least because of the somewhat limited nature of the studies and categories of person studied by Professor Battin but also because the views of the State's witnesses are rooted in their solid clinical experience of dealing with literally thousands of terminally ill patients and both gave their evidence in a manner which greatly impressed the Court. The Court finds that the State has provided an ample evidential basis to support the view that any relaxation of the ban on assisted suicide would be impossible to tailor to individual cases and would be inimical to the public interest in protecting the most vulnerable members of society.

**68.** A further point of some importance is that if physicians were to be permitted to hasten the end of the terminally ill at the request of the patient by taking active steps for this purpose this would be to compromise – perhaps in a fundamental and far-reaching way – that which is rightly regarded as an essential ingredient of a civilised society committed to the protection of human life and human dignity. It might well send out a subliminal message to particular vulnerable groups – such as the disabled and the elderly – that in order to avoid consuming scarce resources in an era of shrinking public funds for health care, physician assisted suicide is a "normal" option which any rational patient faced with terminal or degenerative illness should seriously consider.

**69.** All of this is quite apart from other considerations to which the Oireachtas could properly attach great weight. These factors include obvious and self-evident considerations such as preserving the traditional integrity of the medical profession as healers of the sick and deterring suicide and anything that smacks of the "normalisation" of suicide. Nor could the ancient maxim *qui facit per alium facit per se* (he who does something through another does it himself) be applied to questions of life and death as if this were a routine commercial contract. One could, of course, present physician assisted suicide as simply a humanitarian measure designed to assist the gravely ill via a form of agency to achieve that which they could (and, in many cases, perhaps would) freely do if they were able bodied. It is nevertheless idle to suggest that even the intentional taking of another's life – even if this is consensual - or actively assisting them so to do does not have objective moral dimensions. There must accordingly be a danger that the physician who has participated in this process will, over time, become accustomed to this new prevailing paradigm. In that environment, the risk of complacency with regard to the maintenance of statutory safeguards – which all are agreed would be absolutely essential – could not be discounted as negligible.

**70.** In this regard, one must have regard to the Dutch data (some of which will be further considered below in conjunction with this Court's analysis of the decision in *Carter v. Canada* [2012] BCSC 886) which showed that at times there was an "almost total lack of

control on the administration of euthanasia" (Keown, "The Dutch Experience: controlling VAE? Condoning NVAE?" in *Euthanasia, Ethics and Public Policy*: *An Argument against Legalisation* (Cambridge, 2002) at 143) and an earlier acknowledgment by a leading Dutch researcher on the topic that non-voluntary euthanasia cases do form "a very serious problem" (van Delden, "Slippery slopes in flat countries – a response" *Journal of Medical Ethics* 1999; 25:22-24). Indeed, Professor Keown noted that Dr. van Delden had "nowhere sought to question the central criticism [of Dutch practice post liberalisation of the law] that the guidelines have been widely breached and have failed to ensure effective control" (Keown, *Dutch Experience*, p. 143). Professor Hicks noted in her paper, "Physician-assisted suicide: a review of the literature concerning practical and clinical implications for UK doctors" *BMC Family Practice* (2006) 7: 39 that "coercion can be difficult for doctors to detect and even when detected it is sometimes ignored despite guidelines." She went on to give some specific examples of instances of coercion and abuse recorded in the medical literature in respect of both Oregon and the Netherlands in the aftermath of the liberalisation of assisted suicide legislation. Case 3 in her Table 2 was in the following terms:

> "**Case 3: The Netherlands**: A wife who no longer wishes to care for her sick, elderly husband gives him a choice between euthanasia and admission to a nursing home. Afraid of being left to the mercy of strangers in an unfamiliar place, he chooses euthanasia. His doctor ends his life despite being aware that the request was coerced."

**71.** Examples like these, even if exceptional, are nonetheless deeply disturbing and show that the risks of abuse must be regarded as real and cannot simply be dismissed as speculative or distant. Just as seriously, the dilution of the statutory ban might over time gradually lead to the unintentional erosion of moral and ethical standards among medical practitioners, the results of which none could presently foresee.

**72.** It is true that under our proportionality analysis a complete statutory ban which overrides or significantly interferes with a constitutional right requires compelling justification. This may be regarded as especially true in the case of intimate, sensitive and difficult choices in relation to profound issues touching on personal autonomy such as in the present case. Yet the Court believes that the Oireachtas was fully entitled to adopt the solution which it did in enacting the 1993 Act, not least when regard is had to the wider public policy considerations to which the Court has already alluded and the parallel duty which is also placed on the State by Article 40.3.2 to safeguard the right to life.

**THE PROPORTIONALITY OF THE CURRENT BAN ON ASSISTED SUICIDE**

**73.** The Court commences this analysis with a re-statement of the familiar and authoritative exposition of this doctrine by Costello J. in *Heaney v. Ireland* [1994] 3 I.R. 593, 607:-

> "In considering whether a restriction on the exercise of rights is permitted by the Constitution, the courts in this country and elsewhere have found it helpful to apply the test of proportionality, a test which contains the notions of minimal restraint on the exercise of protected rights, and of the exigencies of the common good in a democratic society. This is a test frequently adopted by the European Court of Human Rights (see, for example, *Times Newspapers Ltd. v. United Kingdom* (1979) 2 E.H.R.R. 245) and has recently been formulated by the Supreme Court in Canada in the following terms. The objective of the impugned provision must be of sufficient importance to warrant overriding a constitutionally protected right. It must relate to concerns pressing and substantial in a free and democratic society. The means chosen must pass a proportionality test. They must:-
>
> (a) be rationally connected to the objective and not be arbitrary, unfair or based on irrational considerations;
>
> (b) impair the right as little as possible; and
>
> (c) be such that their effects on rights are proportional to the objective; see *Chaulk v. R.* [1990] 3 S.C.R. 1303, at pages 1335 and 1336."

**74.** Applying this analysis, it can be said immediately that the State has a profound and overwhelming interest in safeguarding the sanctity of all human life – this, after all, is an express and solemn constitutional commitment contained in Article 40.3.2 itself, which right Denham J. described in *Re Ward of Court* [1996] 2 I.R.73, 160 as "the pre-eminent personal right." In this respect Article 40.3.2 commits the State to protecting the sanctity of all human life. This is a normative statement of profound constitutional significance, since in conjunction with the equality guarantee in Article 40.1, it commits the State to valuing *equally* the life of *all* persons. In the eyes of the Constitution, the last days of the life of an elderly, terminally ill and disabled patient facing death have the same value, possess the same intrinsic human dignity and naturally enjoy the same protection as the life of the healthy young person on the cusp of adulthood and in the prime of their life. These are, of course, concerns which any free and democratic society must strive to protect and uphold.

**75.** The prohibition on assisted suicide is rationally connected to this fundamental objective of protecting life and is not remotely based on arbitrary, unfair or irrational considerations. The Court appreciates, of course, that from Ms. Fleming's perspective it seems unfair that she is condemned by the law and society to endure that which, for the rest of the able-bodied population, we could not endure and would not personally tolerate.

**76.** Yet the fact remains that if this Court were to unravel a thread of this law by even the most limited constitutional adjudication in her favour, it would – or, at least, might – open a Pandora's Box which thereafter would be impossible to close. In particular, by acting in a manner designed to respect her conscientious claims and to relieve her acute suffering and distress, this Court might thereby place the lives of others at risk. The Court is well aware that such is not the intention of Ms. Fleming and we are fully conscious that those who urge such change profoundly disclaim any such intention. But such might well be the unintended *effect* of such a change, specifically because of the inability of even the most rigorous system of legislative checks and balances to ensure, in particular, that the aged, the disabled, the poor, the unwanted, the rejected, the lonely, the impulsive, the financially compromised and the emotionally vulnerable would not disguise their own personal preferences and elect to hasten death so as to avoid a sense of being a burden on family and society. The safeguards built into any liberalised system would, furthermore, be vulnerable to laxity and complacency and might well prove difficult or even impossible to police adequately.

**77.** For all of these reasons, the Court considers that the absolute prohibition on assisted suicide also satisfies the second and third limbs of the proportionality test. It follows, therefore, that we find ourselves compelled to reject the constitutional challenge insofar as it concerns the claim based on the protection of the person in Article 40.3.2 (including overlapping and ancillary rights, such as dignity and bodily integrity).

**DECISIONS OF THE HOUSE OF LORDS, THE EUROPEAN COURT OF HUMAN RIGHTS, THE US SUPREME COURT, THE SUPREME**

**COURT OF BRITISH COLUMBIA AND THE CANADIAN SUPREME COURT**

**78.** The Court was privileged to receive a detailed analysis from counsel on all sides of the case-law on this difficult topic from a number of jurisdictions with similar constitutional provisions (such as the United States and Canada) and decisions examining the applicable provisions of the European Convention on Human Rights. While the case-law betrays subtle and nuanced differences of approach in respect of constitutional adjudication, it will be seen that, subject to one recent first instance Canadian decision (*Carter v. Canada*), there is near judicial unanimity on the question of constitutional validity and compatibility with the European Convention on Human Rights of measures which preclude assisted suicide. In particular, every appellate Court has stressed as compelling the considerations which the Court has ventured to elaborate in this judgment. The Court proposes first to consider the position of the US Supreme Court.

**THE US SUPREME COURT: *WASHINGTON v. GLUCKSBERG* AND *VACCO v. QUILL***

**79.** In *Washington v. Glucksberg* 521 US 207 (1997) the US Supreme Court rejected a challenge to the constitutionality of a Washington statute which prevented assisted suicide and reversed a finding to the contrary by the US Court of Appeals for the 9th Circuit. The claim was brought by several Washington physicians who had stated that they would assist terminally ill patients to end their own lives were it not for the ban. Three terminally ill patients who were co-litigants died before the case reached the US Supreme Court.

**80.** It is true that the Court rejected the suggestion that the right to assisted suicide was part of the "liberty" interest protected by the 14th Amendment of the US Constitution. (In Irish terms, this is more or less the same as holding that the right to assisted suicide was not an unenumerated personal right for the purposes of Article 40.3.1). It is further true that the majority insisted that the 14th Amendment protected only those implied rights "which are, objectively, deeply rooted in the [United States] history and tradition." Counsel for the plaintiff, Mr. Murray S.C., urged the Court to discount the precedential value of this authority by noting – correctly – that neither this Court nor the Supreme Court has ever held that the implied personal rights protected by Article 40.3.1 are *only* those with deep roots in our own legal history and tradition. As he pointed out, if that were so, then it would never have been possible, for example, for the Supreme Court to arrive at the conclusion which it did in *McGee v. Attorney General* [1974] I.R. 284.

**81.** But the fact that the US Supreme Court did not find that such a right was protected by the 14th Amendment – whereas, conversely, this Court has found that the right to the protection of the person in Article 40.3.2 is engaged by the operation of the ban – in truth really matters little so far as the core of the case is concerned, because in any event Rehnquist C.J. went on to offer practical justifications for the rationality of the Washington statute (521 U.S. at 731-735):

> "Next, the State has an interest in protecting vulnerable groups–including the poor, the elderly, and disabled persons–from abuse, neglect, and mistakes. The Court of Appeals dismissed the State's concern that disadvantaged persons might be pressured into physician assisted suicide as 'ludicrous on its face' 79 F. 3d, at 825. We have recognized, however, the real risk of subtle coercion and undue influence in end of life situations. *Cruzan*, 497 U.S. at 281. Similarly, the New York Task Force warned that [l]egalizing physician assisted suicide would pose profound risks to many individuals who are ill and vulnerable. . . . The risk of harm is greatest for the many individuals in our society whose autonomy and well being are already compromised by poverty, lack of access to good medical care, advanced age, or membership in a stigmatized social group.' New York Task Force 120; see Compassion in Dying, 49 F. 3d, at 593 ('[A]n insidious bias against the handicapped–again coupled with a cost saving mentality–makes them especially in need of Washington's statutory protection'). If physician assisted suicide were permitted, many might resort to it to spare their families the substantial financial burden of end of life health care costs.
>
> The State's interest here goes beyond protecting the vulnerable from coercion; it extends to protecting disabled and terminally ill people from prejudice, negative and inaccurate stereotypes, and 'societal indifference'49 F. 3d, at 592. The State's assisted suicide ban reflects and reinforces its policy that the lives of terminally ill, disabled, and elderly people must be no less valued than the lives of the young and healthy, and that a seriously disabled person's suicidal impulses should be interpreted and treated the same way as anyone else's. See *New York Task Force 101-102; Physician Assisted Suicide and Euthanasia in the Netherlands: A Report of Chairman Charles T. Canady*, at 9, 20 (discussing prejudice toward the disabled and the negative messages euthanasia and assisted suicide send to handicapped patients).
>
> Finally, the State may fear that permitting assisted suicide will start it down the path to voluntary and perhaps even involuntary euthanasia. The Court of Appeals struck down Washington's assisted suicide ban only 'as applied to competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors.' 79 F. 3d, at 838. Washington insists, however, that the impact of the court's decision will not and cannot be so limited…. If suicide is protected as a matter of constitutional right, it is argued, 'every man and woman in the United States must enjoy it.' *Compassion in Dying*, 49 F. 3d, at 591; see *Kevorkian*, 447 Mich., at 470, n. 41, 527 N. W. 2d, at 727-728, n. 41. The Court of Appeals' decision, and its expansive reasoning, provide ample support for the State's concerns. The court noted, for example, that the 'decision of a duly appointed surrogate decision maker is for all legal purposes the decision of the patient himself,' 79 F. 3d, at 832, n. 120; that 'in some instances, the patient may be unable to self administer the drugs and . . . administration by the physician . . . may be the only way the patient may be able to receive them,' *id.*, at 831; and that not only physicians, but also family members and loved ones, will inevitably participate in assisting suicide. *Id.*, at 838, n. 140. Thus, it turns out that what is couched as a limited right to 'physician assisted suicide' is likely, in effect, a much broader license, which could prove extremely difficult to police and contain. Washington's ban on assisting suicide prevents such erosion.
>
> This concern is further supported by evidence about the practice of euthanasia in the Netherlands. The Dutch government's own study revealed that in 1990, there were 2,300 cases of voluntary euthanasia (defined as 'the deliberate termination of another's life at his request'), 400 cases of assisted suicide, and more than 1,000 cases of euthanasia without an explicit request. In addition to these latter 1,000 cases, the study found an additional 4,941 cases where physicians administered lethal morphine overdoses without the patients' explicit consent. *Physician Assisted Suicide and Euthanasia in the Netherlands: A Report of Chairman Charles T. Canady*, at 12-13 (citing Dutch study). This study suggests that, despite the existence of various reporting procedures, euthanasia in the Netherlands has not been limited to competent, terminally ill adults who are enduring physical suffering, and that regulation of the practice may not have prevented abuses in cases involving vulnerable persons, including severely disabled neonates and elderly persons suffering from dementia. *Id.*, at 16-21; see generally C. Gomez, *Regulating Death: Euthanasia and the Case of the Netherlands* (1991); H. Hendin, *Seduced By Death: Doctors, Patients, and the Dutch Cure* (1997). The New York Task Force, citing the Dutch experience, observed that 'assisted suicide and euthanasia are closely linked,' New York Task Force 145, and concluded that the 'risk of . . . abuse is neither speculative nor distant,' id., at 134. Washington, like most other States,

reasonably ensures against this risk by banning, rather than regulating, assisting suicide. See *United States v. 12,200-ft Reels of Super 8MM Film*, 413 U.S. 123, 127 (1973) ('Each step, when taken, appear[s] a reasonable step in relation to that which preceded it, although the aggregate or end result is one that would never have been seriously considered in the first instance').

We need not weigh exactingly the relative strengths of these various interests. They are unquestionably important and legitimate, and Washington's ban on assisted suicide is at least reasonably related to their promotion and protection. We therefore hold that Wash. Rev. Code 9A.36.060(1) (1994) does not violate the Fourteenth Amendment, either on its face or 'as applied to competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors.' 79 F. 3d, at 838."

**82.** It is true that these words were uttered in the context of a rationality analysis (*i.e.*, the lower-level intensity review of a statute which the US courts perform when no fundamental constitutional rights are engaged). But the reasoning seems to this Court to be compelling.

**83.** In the companion case, *Vacco v. Quill* 521 U.S. 793, which was decided on the same day as *Glucksberg*, the US Supreme Court upheld the constitutionality of a New York statute banning assisted suicide which was in very similar terms to our own. Here again Rehnquist C.J. observed:

"….we disagree with respondents' claim that the distinction between refusing lifesaving medical treatment and assisted suicide is 'arbitrary' and 'irrational' Granted, in some cases, the line between the two may not be clear, but certainty is not required, even were it possible. Logic and contemporary practice support New York's judgment that the two acts are different, and New York may therefore, consistent with the Constitution, treat them differently. By permitting everyone to refuse unwanted medical treatment while prohibiting anyone from assisting a suicide, New York law follows a longstanding and rational distinction.

New York's reasons for recognizing and acting on this distinction–including prohibiting intentional killing and preserving life; preventing suicide; maintaining physicians' role as their patients' healers; protecting vulnerable people from indifference, prejudice, and psychological and financial pressure to end their lives; and avoiding a possible slide towards euthanasia–are discussed in greater detail in our opinion in *Glucksberg*…. These valid and important public interests easily satisfy the constitutional requirement that a legislative classification bear a rational relation to some legitimate end."

**84.** The Court agrees entirely with these views and would merely add that these reasons in our view are not merely adequate to sustain a law on the low-intensity "rationality review" test favoured by the US Supreme Court in cases of this kind, but would also amply justify the ban by reference to the proportionality analysis which the Court has just conducted.

***RODRIGUEZ v. CANADA***

**85.** The decision of the Canadian Supreme Court in *Rodriguez v. Canada* [1993] 3 SCR 519 is of considerable assistance and interest, not least given that the actual language of s. 7 of the Canadian Charter of Rights is very similar to that of Article 40.3.2 itself:

"Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice."

**86.** In *Rodriguez* the applicant was a middle aged woman who suffered from amyotrophic lateral sclerosis (commonly known as Lou Gehrig's disease). Her condition was deteriorating rapidly and she would soon lose the ability to swallow, speak, walk, and move. She sought physician assisted suicide. While the Canadian Supreme Court held that her right to the protection of the person under s. 7 of the Charter was engaged by the absolute prohibition on assisted suicide contained in s. 241(b) of the Canadian Criminal Code, a majority of the Court held that the prohibition was nonetheless justified on proportionality grounds.

**87.** Sopinka J. pointed out that the prohibition had "a clearly pressing and substantial legislative objective grounded in the respect for and the desire to protect human life, a fundamental Charter value." On the wider proportionality issue, Sopinka J. concluded:

"On the issue of proportionality, which is the second factor to be considered under s.1, it could hardly be suggested that a prohibition on giving assistance to commit suicide is not rationally connected to the purpose of s. 241(*b*). The Chief Justice does not suggest otherwise. Section 241(*b*) protects all individuals against the control of others over their lives. To introduce an exception to this blanket protection for certain groups would create an inequality. As I have sought to demonstrate in my discussion of s. 7, this protection is grounded on a substantial consensus among western countries, medical organizations and our own Law Reform Commission that in order to effectively protect life and those who are vulnerable in society, a prohibition without exception on the giving of assistance to commit suicide is the best approach. Attempts to fine tune this approach by creating exceptions have been unsatisfactory and have tended to support the theory of the 'slippery slope'. The formulation of safeguards to prevent excesses has been unsatisfactory and has failed to allay fears that a relaxation of the clear standard set by the law will undermine the protection of life and will lead to abuses of the exception. The recent Working Paper of the Law Reform Commission, quoted above, bears repeating here:

> 'The probable reason why legislation has not made an exception for the terminally ill lies in the fear of the excesses or abuses to which liberalization of the existing law could lead. As in the case of "compassionate murder", decriminalization of aiding suicide would be based on the humanitarian nature of the motive leading the person to provide such aid, counsel or encouragement. As in the case of compassionate murder, moreover, the law may legitimately fear the difficulties involved in determining the true motivation of the person committing the act.'

The foregoing is also the answer to the submission that the impugned legislation is overbroad. There is no halfway measure that could be relied upon with assurance to fully achieve the legislation's purpose; first, because the purpose extends to the protection of the life of the terminally ill. Part of this purpose, as I have explained above, is to discourage the terminally ill from choosing death over life. Secondly, even if the latter consideration can be stripped from the legislative purpose, we have no assurance that the exception can be made to limit the taking of life to those who are terminally ill and genuinely desire death."

It will be seen that this analysis of the proportionality issue substantially accords with the views just expressed by this Court. The decision in *Rodriguez* was understood to represent the law in Canada until the more recent decision of Lynn Smith J. in *Carter v. Canada* delivered in June 2012. This enormously comprehensive judgment deserves extended consideration and we propose to

consider it now in some detail.

***CARTER v. CANADA***

**88.** In *Carter v. Canada* [2012] BCSC 886 the compatibility of the ban on assisted suicide contained in s. 241(b) of the Canadian Criminal Code with the Canadian Charter of Rights and Freedoms was considered by Lynn Smith J. sitting at first instance in the Supreme Court of British Columbia. The action was brought by two plaintiffs with debilitating and degenerative diseases, as well as by the husband of one such plaintiff and a family physician. One of the fundamental questions before the court was whether it was possible to revisit the earlier *Rodriguez* decision decided by the Canadian Supreme Court some nineteen years previously. In an enormously lengthy and comprehensive judgment, Lynn Smith J. concluded that she could and she proceeded to hold the ban unconstitutional as disproportionate. During the course of the present hearing the Court was informed that this decision is currently under appeal.

**89.** The evidence given in this case was truly comprehensive and included many expert witnesses who have studied and written about this topic and whose work is independently referenced in this judgment, including Professor Battin, Professor Ganzini, Professor Keown, Baroness Finlay, Dr. Hendin and Professor van Delden. Much of that evidence focussed on the experience of liberalisation in jurisdictions such as Oregon, the Netherlands and Belgium which provided for physician-assisted suicide and the risks involved were the prohibition on assisted suicide to be relaxed

**90.** Two principal reasons were given for Lynn Smith J.'s conclusions. First, the proportionality analysis had been significantly developed in the meantime, specifically by reference to the decision of the Canadian Supreme Court in *Alberta v. Hutterian Brethern of Wilson Colony* (2009) SCC 37. Second, new evidence was available from other jurisdictions where the law had been relaxed which had not been available to the Canadian Supreme Court in *Rodriguez*. Although our own proportionality analysis has been hugely influenced by Canadian law, it would be inappropriate for us in this context to comment or purport to analyse the manner in which the Canadian courts have developed and refined their own proportionality analysis over the last two decades or so.

**91.** The second reason – the new evidence – is, however, of considerable significance to the present case. On this point Lynn Smith J. said (at paras. 1235-1244 of the judgment):

> "The real question is whether a prohibition with exceptions would, in practical application, place patients at risk because of the difficulty in designing and applying the exceptions.
>
> Canada and British Columbia both point to multiple possible sources of error. Prognostic predictions about the length of a person's remaining life can be wrong. Cognitive impairment, depression or other mental illness in a patient can be overlooked, especially when the physician has not had a long-term relationship with the patient. Coercion or influence from persons who do not see value in the patient's life or who might stand to gain from a patient's hastened death can escape detection. People who seem resolute about their wish to die may in fact be ambivalent. Insufficient pain management or symptom control can undermine a patient's will to live. The possibility of such errors gives rise to risks.
>
> The plaintiffs suggest, however, that the very same risks exist with respect to current end-of-life practices. A patient who chooses to withdraw from life-sustaining treatment may present exactly the same challenges to caregivers, who need to know if the patient is truly giving informed consent, is not suffering from untreated depression, or is acting under some kind of duress or coercion.
>
> I have reviewed the evidence regarding the inherent challenges in creating and enforcing safeguards that depend upon physicians' assessment of matters such as competence, voluntariness and non-ambivalence. As well, I have reviewed the evidentiary record, particularly regarding Oregon, the Netherlands and Belgium, where much research has been done and data accumulated. This Court has had the benefit of the opinions of respected scientists, medical practitioners and other persons who are familiar with the end-of-life decision-making both in Canada and in other jurisdictions.
>
> The evidence shows that the effectiveness of safeguards depends upon, among other factors, the nature of the safeguards, the cultural context in which they are situate, the skills and commitment of the physicians who are responsible for working within them, and the extent to which compliance with the safeguards is monitored and enforced.
>
> In my view, the evidence supports the conclusion that the risks of harm in a regime that permits physician-assisted death can be greatly minimized. Canadian physicians are already experienced in the assessment of patients' competence, voluntariness and non-ambivalence in the context of end-of-life decision-making. It is already part of sound medical practice to apply different levels of scrutiny to patients' decisions about different medical issues, depending upon the gravity of the consequences. The scrutiny regarding physician-assisted death decisions would have to be at the very highest level, but would fit within the existing spectrum. That spectrum already encompasses decisions where the likely consequence of the decision will be the death of the patient.
>
> Further, the evidence from other jurisdictions shows that the risks inherent in legally permitted assisted death have not materialized in the manner that may have been predicted. For example, in both the Netherlands and Belgium, the legalization of physician-assisted death emerged in a context in which medical practitioners were already performing life-ending acts, even without the explicit request of their patients. After legalization, the number of LAWER ["legally assisted without explicit request"] deaths has significantly declined in both jurisdictions. This evidence serves to allay fears of a practical slippery slope.
>
> The evidence does not support the conclusion that, since the legalization of physician-assisted death, there has been a disproportionate impact, in either Oregon or the Netherlands, on socially vulnerable groups such as the elderly or persons with disabilities. While there is some evidence of a heightened risk to persons with HIV/AIDS, that evidence pre-dates the development of highly effective antiretroviral medications.
>
> A less drastic means of achieving the objective of preventing vulnerable persons from being induced to commit suicide at times of weakness would be to keep the general prohibition in place but allow for a stringently limited, carefully monitored system of exceptions. Permission for physician-assisted death for grievously ill and irremediably suffering people who are competent, fully informed, non-ambivalent, and free from coercion or duress, with stringent and well-enforced safeguards, could achieve that objective in a real and substantial way.
>
> I conclude that the defendants have failed to show that the legislation impairs Ms. Taylor's Charter rights as little as

possible."

**92.** While no mere summary of ours could do justice to this enormously comprehensive judgment, the above passages are the heart of the judge's conclusions that the absolute prohibition failed the proportionality test. But in the light of the evidence that was presented to her and, indeed, to us, this Court respectfully disagrees with this analysis for the following reasons.

**93.** First, it is true that similar issues of informed consent attend the decision of the seriously ill patient to refuse to continue life sustaining treatment on the one hand and physician assisted suicide on the other. But the similarity ends there, since for the reasons we have already set out, there is an enormous and defining difference between the decision of the competent patient to refuse treatment and physician assisted suicide. As we have pointed out – and as Laffoy J. held in *Fitzpatrick v. FK* - the State cannot constitutionally *compel* the competent adult patient to accept medical treatment, since this would be wholly at variance with the obligation to protect the person in Article 40.3.2. It is, however, a fallacy to suppose that physician assisted suicide can be equated with this, precisely because it involves *active participation* by another in the intentional killing of that other, even if this is genuinely and freely consensual.

**94.** Second, we simply cannot agree that the accumulated evidence from other jurisdictions to which the judge referred "shows that the risks inherent in legally permitted death have not materialized in the manner that may have been predicted." At an earlier part of her judgment Lynn Smith J. had observed (at paras. 654-660 of the judgment):

> "In both the Netherlands and Belgium, where there has been extensive documentation and research, the data are much more detailed and complete.
>
> In the Netherlands, the studies over the years show that there is now much greater compliance than there was pre-legalization with the requirement to report cases of euthanasia; 80% of cases were reported in 2005, up from 18% in 1990. Cases of LAWER continue (thus, cases in which there is non-compliance with the requirement for express request in writing, and possibly with other requirements). The trend is that LAWER cases are declining in numbers (from 1,000 in 1990 to 550 in 2005), although it is important to note that the number of LAWER cases prior to law reform is unknown. Professor Lewis suggests that since 99% of cases involving typical euthanasia drugs are reported, mislabelling by physicians may explain most unreported cases: some physicians do not label death following the administration of other drugs (e.g. morphine) as euthanasia. Dr. van Delden gives similar evidence in this regard.
>
> The evidence supports the conclusion that the compliance with the safeguards in the Netherlands is continually improving, but that it is not yet at an ideal level.
>
> In Belgium there are still low rates of reporting (only approximately 53% of presumed cases of euthanasia were reported in 2007) and high rates of LAWER. However, Professor Lewis's evidence is that the number of LAWER cases has declined since legalization of assisted death.
>
> The defendants argue that what the data show is that increased enforcement of the laws in Belgium, during a time when legal change was being debated, caused the rates of LAWER to decline; the rate dropped from 3.2% in 1998 (prior to the political and social debate surrounding legalization of euthanasia) to 1.5% (mid-debate) in 2001 and then rose again (post-legalization) to 1.8% in 2007. Professor Deliens, on the other hand, emphasizes the comparison between pre-legislation and the present day, and says that an increase from 1.5% to 1.8% lacks statistical significance in the context of these data.
>
> The low rate of reporting in Belgium may have a similar explanation to that suggested above with respect to the Netherlands. I also note that the Smets et al. Reporting Study indicates that physicians who perceive their case to constitute euthanasia report 93.1% of the time. Dr. Bernheim's evidence, giving the opinion that the legislative change in Belgium has improved the carefulness of end-of-life practice, and Professor Deliens's evidence to similar effect, is persuasive.
>
> The evidence suggests that in some measure the impetus toward permissive legislation in the Netherlands and Belgium came from the desire to achieve better understanding, and regulation, of practices of assisted death that were already prevalent and embedded in the medical culture. Looked at in that light, the law reforms in both jurisdictions have made considerable progress in achieving their goals."

**95.** This Court acknowledges, of course, that no system of administration is perfect and that some allowances have to be made for errors, even if in this context errors – such as, for example, the failure to detect depression or coercion on the part of patients opting for physician assisted suicide – have fatal and irreversible consequences. But all parties in this case are agreed that if the prohibition on assisted suicide were to be relaxed, it would have to be operated by reference to the highest possible degree of safeguards.

**96.** Neither the evidence tendered at the hearing before us or the evidence given before Lynn Smyth J. regarding contemporary practice in either the Netherlands or Belgium can be regarded as encouraging or satisfactory. After all, it was not in dispute but that in 2005 - the year for which the latest data is available for the Netherlands – 560 patients (some 0.4% of *all* deaths) were euthanized without having given their explicit consent.

**97.** Lynn Smith J. further recorded (at para. 484) that evidence was given that:

> "the judicially developed necessity defence continues to apply outside of the Dutch Act to LAWER cases involving incompetent persons, including neonates. Thus, in some cases…termination of life without request is legally justified in the Netherlands."

**98.** While Professor van Delden was recorded by Lynn Smith J. (at para. 486) as acknowledging that the LAWER cases "are a serious matter", he considered that they "are not necessarily proof of a slippery slope from physician-assisted dying on explicit request to non-voluntary euthanasia."

**99.** The corresponding figure for Belgium is apparently higher, as 1.9% of *all* deaths which took place in the entirety of Flanders between June and November 2007 were without explicit request: see T. Smets *et al.*, "Reporting of euthanasia in medical practice in Flanders, Belgium: cross-sectional analysis of reported and unreported cases" (2010) 341 *British Medical Journal* c. 5714; K. Chambaere *et al.*, "Physician-assisted deaths under the euthanasia law in Belgium: a population-based survey" 182:9 *Can Med Assoc J.* 895. and paras. 559-568 of Lynn Smith J.'s judgment. As it happens, Lynn Smith J. noted (at para. 600) that the corresponding

figure for Switzerland was also high, with "Swiss doctors carry[ing] out euthanasia and termination of life "without explicit request of the patient in almost 1% of *all* deaths" – our emphasis – even if this fact apparently provokes "no reaction from Swiss public prosecutors."

**100.** Lynn Smith J. herself recognised (at para. 569) that the evidence was that "family burden and the consideration that life not be needlessly prolonged were more often cited as reasons for LAWER." She added that the authors of the Chambaere study believed that:

> "LAWER cases often involved chronically ill patients whose general conditions suddenly and drastically deteriorated to the point where they were left permanently unable to communicate. In these situations, the authors say, physicians need to decide on a course of action together with the patient's family, which may result in a conflict of interest. This underscores the importance of advance care planning together with family and caregiver, and of communication regarding the patient's wishes should he or she become comatose or incompetent. They opine that such measures will undoubtedly limit the number of LAWER cases."

**101.** Lynn Smith J. noted (at paras. 572 and 573) that the authors further commented:

> "Our finding that euthanasia and assisted suicide were typically performed in younger patients, patients with cancer and patients dying at home is consistent with findings from other studies. Our finding that the use of life-ending drugs without explicit patient request occurred predominantly in hospital and among patients 80 years or older who were mostly in a coma or had dementia fits the description of 'vulnerable' patient groups at risk of life-ending without request. Attention should therefore be paid to protecting these patient groups from such practices. However, when compared with all deaths in Flanders, elderly patients and patients dying of diseases of the nervous system (including dementia) were not proportionately at greater risk of this practice than other patient groups….
>
> We found that the use of life-ending drugs without a patient's explicit request occurred more often in Flanders, Belgium, than in other countries, including the Netherlands, where euthanasia is also legal. Flemish physicians have been shown to be more open to this practice than physicians elsewhere, which suggests a larger degree of paternalistic attitudes. This being said, its occurrence has not risen since the legalization of euthanasia in Belgium. On the contrary, the rate dropped from 3.2% in 1998 to 1.8% in 2007. In the Netherlands, the rate dropped slightly after legalization, from 0.7% to 0.4%. Although legalization of euthanasia seems to have had an impact, more efforts are needed to further reduce the occurrence of life-ending drug use without an explicit request from the patient."

**102.** It will be seen from this necessarily compressed survey of the comparative evidence so comprehensively summarised by Lynn Smith J. in *Carter* that the incidence of legally assisted death without explicit request in the Netherlands, Belgium and Switzerland is strikingly high. This practice is acknowledged to be unlawful, although the application of legally assisted deaths without explicit request to certain categories of incompetent patients (such as, *e.g.*, seriously disabled neonates) is apparently lawful in the Netherlands.

**103.** Furthermore, the Chambaere study expressly found that "family burden" was one of the reasons for the practice of LAWER in Flanders. It further suggested – although Lynn Smith J. noted (at paras. 576-577) that one of the authors, a Professor Deliens, had apparently denied this – that the use of LAWER predominated in respect of the elderly who were in a coma or who were demented, *i.e.*, precisely one of the vulnerable groups most at risk. Lynn Smith J.'s later finding that liberalisation did not have a disproportionate impact "on socially vulnerable groups such as the elderly or persons with disabilities" has to be measured against this actual evidence, as well as the evidence (also apparently accepted by her) that LAWER was not infrequently practised in the Netherlands on disabled neonates, even if this practice is lawful under Dutch law.

**104.** Against that general background, the Court cannot at all agree with Lynn Smith J.'s finding that the risks inherent in legally permitted assisted death have not materialized in jurisdictions such as Belgium and the Netherlands, even if it is true that the incidence of LAWER in those jurisdictions has "significantly declined" since liberalisation. While this Court fully agrees with Lynn Smith J. that the "scrutiny regarding physician-assisted death decisions would have to be at the highest level", we would simply observe in this general regard that she herself acknowledged that compliance with essential safeguards in the Netherlands – more than thirty years after liberalisation - was "not yet at an ideal level." In fact, it might well be said that this is altogether too sanguine a view and that the fact such a strikingly high level of legally assisted deaths without explicit request occurs in countries such as Belgium, Netherlands and Switzerland without any obvious official or even popular concern speaks for itself as to the risks involved in any such liberalisation.

**105.** For all of these reasons, therefore, this Court finds that it cannot agree with Lynn Smith J.'s analysis of both the evidence and the relevant legal principles. It follows, therefore, that we would respectfully prefer the reasoning of Sopinka J. in *Rodriguez* to that of Lynn Smith J. in *Carter*.

**THE *PRETTY* CASE**

**106.** In *R. (Pretty) v. Director of Public Prosecutions* [2001] UKHL 61, [2002] 1 A.C. 800 the applicant suffered from a debilitating motor neurone disease and was terminally ill. She sought the assistance of her husband to help her end her own life, but only if there could be an assurance that he would not be prosecuted for assisting her to do so. Lord Bingham described the distinction between suicide on the one hand and assisting another to commit suicide as one which was "deeply embedded" in the fabric of English law. He also stressed the fundamental difference between the cessation of medical treatment on the one hand and active assistance to end life on the other. Lord Bingham accordingly concluded that Article 8 was not engaged by the prohibition on assisted suicide, but if it was, the section was not incompatible with it.

**107.** Ms. Pretty then brought the matter before the European Court of Human Rights: see *Pretty v. United Kingdom* (2002) 35 EHRR 1. The European Court disagreed (or, at least, seems to have disagreed) with the House of Lords' opinion that Article 8 was not engaged, but, critically, it agreed that Article 8 was not breached. As to the engagement of Article 8, the Court said:

> "65. The very essence of the Convention is respect for human dignity and human freedom. Without in any way negating the principle of sanctity of life protected under the Convention, the Court considers that it is under Article 8 that notions of the quality of life take on significance. In an era of growing medical sophistication combined with longer life expectancies, many people are concerned that they should not be forced to linger on in old age or in states of advanced physical or medial decrepitude which conflict with strongly held ideas of self and personal identity……

67. The applicant in this case is prevented by law from exercising her choice to avoid what she considers will be an undignified and distressing end to her life. The Court is not prepared to exclude that this constitutes an interference with her right to respect for private life as guaranteed under Article 8(1) of the Convention. It considers below whether this interference conforms with the requirements of the second paragraph of Article 8." (Emphasis added)

**108.** While the underlined words appears to have troubled both the Divisional Court and Court of Appeal in *Purdy* as to whether in fact the European Court had disagreed with the House of Lords (see the judgment of Lord Hope in *Purdy* at paras. 37-39, [2009] 3 WLR 403, 417), there seems little doubt but that the Court had reached this conclusion. In any event, it is clear from the European Court's explicit statement at a later point of the judgment (at para. 86) - in the context of the applicability of the non-discrimination provisions of Article 14 ECHR – that it had found that the applicant's rights under Article 8 were so engaged.

**109.** Turning to the question of compliance with Article 8(2), the court said:

"70. According to the Court's established case law, the notion of necessity implies that the interference corresponds to a pressing social need and, in particular, that it is proportionate to the legitimate aim pursued; in determining whether an interference is 'necessary in a democratic society', the Court will take into account that a margin of appreciation is left to the national authorities, whose decision remains subject to review by the Court for conformity with the requirements of the Convention. The margin of appreciation to be accorded to the competent national authorities will vary in accordance with the nature of the issues and the importance of the interests at stake.…

74. …The law in issue in this case, section 2 of the 1961 Act, was designed to safeguard life by protecting the weak and vulnerable and especially those who are not in a condition to take informed decisions against acts intended to end life or to assist in ending life. Doubtless the condition of terminally ill individuals will vary. But many will be vulnerable and it is the vulnerability of the class which provides the rationale for the law in question. It is primarily for States to assess the risk and the likely incidence of abuse if the general prohibition on assisted suicides were relaxed or if exceptions were to be created. Clear risks of abuse do exist, notwithstanding arguments as to the possibility of safeguards and protective procedures.

…

76. The Court does not consider therefore that the blanket nature of the ban on assisted suicide is disproportionate. The Government has stated that flexibility is provided for in individual cases by the fact that consent is needed from the DPP to bring a prosecution and by the fact that a maximum sentence is provided, allowing lesser penalties to be imposed as appropriate…It does not appear to be arbitrary to the Court for the law to reflect the importance of the right to life, by prohibiting assisted suicide while providing for a system of enforcement and adjudication which allows due regard to be given in each particular case to the public interest in bringing a prosecution, as well as to the fair and proper requirements of retribution and deterrence."

**110.** It is against the background of *Pretty* that the subsequent decision of the House of Lords in *Purdy* must be understood. Here the applicant also suffered from primary progressive multiple sclerosis for which there was no known cure. Her case was that she anticipated that there would come a time when she would find her continuing existence as unbearable and that she would desire to bring about her end. She accordingly intended to travel to Switzerland for this purpose. Her husband was willing to assist her to make that journey, but she was concerned that he would be prosecuted under the applicable legislation in the United Kingdom were this to occur.

**111.** The applicant sought information from the Director of Public Prosecutions as to the factors which he would take into account in determining whether there ought to be a prosecution were this to occur, but this he declined to do. The judicial review application which she brought was then directed to this very issue. Here it be may observed that whatever about *Pretty* (where the intended place of death was not specified and, in any event, did not feature as a factor in either the House of Lords or in Strasbourg), the question of whether such conduct (*i.e.*, assisting the applicant to travel to Switzerland) would actually amount to a breach of the law and, if it did, whether this was a factor which the Director would take into account were issues which were far from clear, an issue which, for example, was fully recognised in the judgment of Lord Phillips: see [2009] 3 W.L.R. 403, 406-409.

**112.** These factual considerations were at the heart of Lord Hope's judgment. He pointed out that whatever about possible ambiguities in the judgment, when it is read as a whole the European Court had actually held in *Pretty* that the right to private life in Article 8(1) ECHR was engaged by decisions of this kind. Next, he stressed that legal certainty was a core question to be addressed in considering whether any restrictions on the right to family life were proportionate and "prescribed by law" in the manner provided by Article 8(2), saying ([2009] 3 W.L.R. 403, 418):

"The requirement of foreseeability will be satisfied where the person concerned is able to foresee, if need be with appropriate legal advice, the consequences which a given action may entail. A law which confers a discretion is not in itself inconsistent with this requirement, provided the scope of the discretion and the manner of its exercise are indicated with sufficient clarity to give the individual protection against interference which is arbitrary…"

**113.** And while Lord Hope differed from other members of the House on the question of whether the statutory prohibition would apply to Ms. Purdy's husband - he thought that it did – he held that the Director's guidelines did not address this question (*i.e.*, whether the husband would be likely to be prosecuted if he travelled with her to Switzerland) with sufficient particularity. Critically, however, he went on to say that the Code for Crown Prosecutors which the Director was required to issue pursuant to s. 10 of the (UK) Prosecution of Offences Act 1985 must be treated as the equivalent of a "law" for Article 8(2) purposes ([2009] 3 W.L.R. 403, 420):

"Section 10 of that Act provides that the Director shall issue a Code for Crown Prosecutors giving guidance on general principles to be applied by them in determining, in any case, among other things whether proceedings for an offence should be instituted and that he may from time to time make alterations to the Code. This document is available to the public. *In my opinion the Code is to be regarded, for the purposes of Article 8(2) of the Convention, as forming part of the law in accordance with which an interference with the right to respect for private life may be held to be justified.* The question is whether it satisfies the requirements of accessibility and foreseeability where the question is whether, in an exceptional case such as that which Ms Purdy's circumstances are likely to give rise to, it is in the public interest that proceedings under s. 2(1) should be instituted against those who have rendered assistance."(Emphasis added)

**114.** Judged by that standard, Lord Hope held that the guidelines were inadequate and on that basis the applicant succeeded. While it is true that two members of the House – Lady Hale and Lord Brown – appeared to go further to acknowledge that in some

circumstances a blanket ban on assisted suicide might breach Article 8, this would not seem to have been part of the ratio in *Purdy*: see *R. (Nicholson) v. Ministry of Justice* [2012] EWHC 2381 (Admin.) at paras. 114-115, per Toulson L.J.

**115.** While the Court will return presently to the issue of guidelines in the context of the present case, it will be seen that the ultimate ratio of that decision is of very limited relevance so far as the wider constitutional and ECHR issues with which we are here concerned. All that *Purdy* decided which is relevant to these issue was – in line with *Pretty* – that end of life issues were engaged by Article 8(1) ECHR and that any restrictions on the exercise of that right need to be justified in accordance with Article 8(2) ECHR.

***HAAS v. SWITZERLAND***

**116.** This entire question was most recently considered by the European Court in *Haas v. Switzerland* (2011) 53 EHRR 33. Here the applicant was a Swiss national who suffered from bi-polar disorder and who wished to commit suicide. For this purpose he sought sufficient quantities of a powerful barbiturate which he proposed to self-administer. This drug is only available on prescription and the Swiss public health authorities refused to permit the applicant to acquire this drug without prescription.

**117.** When the Swiss Federal Court found against him, the applicant maintained before the European Court of Human Rights that the refusal to sanction this amounted to a breach of Article 8.

**118.** The European Court stressed that the facts of this case were different from that of *Pretty* inasmuch as the applicant in *Haas* was not suffering from a terminal or degenerative illness. It found that the decision of the Swiss authorities was amply justified by the provisions of Article 8(2) ECHR:

> "56. With regard to the balancing of the competing interests in this case, the Court is sympathetic to the applicant's wish to commit suicide in a safe and dignified manner and without unnecessary pain and suffering, particularly given the high number of suicide attempts that are unsuccessful and which frequently have serious consequences for the individuals concerned and for their families. However, it is of the opinion that the regulations put in place by the Swiss authorities, namely the requirement to submit a medical prescription, pursue, *inter alia*, the legitimate aims of protecting everybody from hasty decisions and preventing abuse, and, in particular, ensuring that a patient lacking discernment does not obtain a fatal dose of sodium pentobarbital …..
>
> 57. Such regulations are all the more necessary in respect of a country such as Switzerland, where the legislation and practice allow for relatively easy access to assisted suicide. Where a country adopts a liberal approach in this manner, appropriate implementation measures for such an approach and preventive measures are necessary. The introduction of such measures is also intended to prevent organisations which provide assistance with suicide from acting unlawfully and in secret, with significant risks of abuse.
>
> 58. In particular, the Court considers that the risks of abuse inherent in a system that facilitates access to assisted suicide cannot be underestimated. Like the Government, it is of the opinion that the restriction on access to sodium pentobarbital is designed to protect public health and safety and to prevent crime. In this respect, it shares the perspective of the Federal Tribunal to the effect that the right to life guaranteed by Article 2 of the Convention obliges States to establish a procedure capable of ensuring that a decision to end one's life does indeed correspond to the free wish of the individual concerned. It considers that the requirement for a medical prescription, issued on the basis of a full psychiatric assessment, is a means enabling this obligation to be met. Moreover, this solution corresponds to the spirit of the International Convention on Psychotropic Substances and the conventions adopted by certain member States of the Council of Europe."

**119.** It will be seen, therefore, that the European Court of Human Rights has consistently taken the view that a ban on assisted suicide will always be justifiable by reference to Article 8(2) ECHR inasmuch as Contracting States are entitled to think that such is necessary to prevent abuse and the exploitation of the vulnerable. But this survey of the contemporary case-law from other jurisdictions shows that the preponderance of judicial opinion in the US, Canada, the United Kingdom and the European Court of Human Rights has been to uphold a ban on assisted suicide for either precisely the same reasons or substantially the same reasons as the ones which the Court has endeavoured to set out. Specifically, experience has shown that it would be all but impossible effectively to protect the lives of vulnerable persons and to guard against the risks of abuses were the law to be relaxed.

**120.** It is true, of course, that individual judges of high international standing have taken a different view of this issue: see here, for example, the dissents of Lamer C.J. and Cory J. in *Rodriguez* and the separate opinions of Baroness Hale and Lord Brown in *Purdy.* Yet it is of some significance that no appellate court has upheld the claims of a litigant in the plaintiff's condition. This is not, of course, because judges – whether here or in other jurisdictions – are indifferent to or are insulated from acute human suffering. It is rather because as all these judgments have sought to explain, it is impossible to craft a solution specific to the needs of a plaintiff such as Ms. Fleming without jeopardising an essential fabric of the legal system – namely, respect for human life – and compromising these protections for others and other groups of individuals who sorely need such protections.

**ARTICLE 40.1: THE ALLEGED VIOLATION OF THE EQUALITY GUARANTEE**

**121.** The Constitution's commitment to equality of treatment in Article 40.1 is, like the guarantee in Article 40.3.2, another example of a normative statement of high moral value. Unlike its European Convention on Human Rights counterpart, Article 14 ECHR, Article 40.1 is a free-standing equality guarantee, the application of which is by no means contingent on the operation of a separate and distinct constitutional right. As the Supreme Court pointed out in *MD v. Ireland* [2012] IESC 10, [2012] 2 I.L.R.M. 305 differences of legislative treatment will generally require at least a degree of objective justification, even if the margin of appreciation permitted to the Oireachtas will be somewhat greater in matters of acute social controversy. In the case of persons with disabilities, within appropriate limits of feasibility and practicality, Article 40.1 will often permit - when it does not otherwise require - separate and distinct legislative treatment of persons with disabilities so that all "are truly held equal before the law in the real sense which the Constitution enjoins": see *DX v. Buttimer* [2012] IEHC 175.

**122.** The Court is prepared to allow that inasmuch as the 1993 Act failed to make separate provision for persons in the plaintiff's position by creating no exception to take account of the physical disability which prevents the plaintiff taking the steps which the able bodied could take, the precept of equality in Article 40.1 is here engaged. But, again, for all the reasons which we have set out with regard to the Article 40.3.2, we consider that this differential treatment is amply justified by the range of factors bearing on the necessity to safeguard the lives of others which we have already set out at some length. There is, moreover, as we have already noted, a profound difference between the law permitting an adult to take their own life on the one hand and sanctioning another to assist that person to that end on the other. This is true even if the very disability under which the plaintiff labours is the very reason

she needs the assistance of others to accomplish this task.

**123.** For these reasons also we must reject the challenge to the constitutionality of the 1993 Act insofar as it is based on the equality guarantee in Article 40.1.

**THE CLAIM BASED ON THE EUROPEAN CONVENTION ON HUMAN RIGHTS ACT 2003**

**124.** The Court will now turn briefly to consider the separate claim for a declaration of incompatibility under s. 5(1) of the 2003 Act. It is clear from the decisions of the European Court of Human Rights in both *Pretty* and *Haas* (which the Court has already discussed at some length) that the plaintiff's case certainly engages her right to private life under Article 8(1) ECHR. But it is equally clear from the reasoning in both cases that Contracting States are permitted to maintain a complete prohibition on assisted suicide for all the reasons which the Court has set out. In the language of Article 8(2), the ban is rationally connected to legitimate state interests pressing in a democratic society, namely, the protection of the right to life, especially of the vulnerable. The prohibition is a proportionate measure designed to promote those interests and the objective it serves cannot be achieved in any less intrusive fashion.

The same may be said in respect of the non-discrimination argument based on Article 14 ECHR and the reasons the Court has already offered in relation to the rejection of the Article 40.1 claim apply *a fortiori* to the Article 14 ECHR claim.

**125.** For these reasons the Court also rejects the claim to a declaration of incompatibility under s. 5(1) of the 2003 Act.

**ROLE OF THE DIRECTOR OF PUBLIC PROSECUTIONS**

**126.** The Court now turns to consider the final issue in the case, namely, the role of the Director of Public Prosecutions and the question of guidelines.

**127.** The Prosecution of Offences Act 1974 ("the Act of 1974") established the Office of the Director of Public Prosecutions and provided for its functions. Essentially the Act provided that the Director should perform all the functions capable of being performed in relation to criminal matters by the Attorney General immediately before the commencement of the Act.

**128.** "Functions" are defined at s. 1 of this Act as including "powers and duties and references to the performance of a function include references to the exercise of a power and the carrying out of a duty". The Director under the Act is a civil servant but is independent in the performance of his or her functions.

**129.** A particular provision of the Act of 1974 provides for the prohibition of certain communications with the Director in relation to criminal proceedings. Section 6 of the Act provides that it shall not be lawful to communicate with the Director in his official capacity for the purpose of influencing the making of a decision to withdraw or not to initiate criminal proceedings or any particular charge in criminal proceedings. However, this prohibition does not apply to communications made by a person who is a defendant or a complainant in criminal proceedings or believes that he is likely to be a defendant in criminal proceedings, or communications made by a person involved in the matter either personally or as legal or medical advisor to a person involved in the matter or as a social worker or a member of the family of a person involved in the matter.

**130.** For the purpose of this section the term "member of the family" is given a wide definition to include "wife, husband, father, mother, grandfather, grandmother, stepfather, stepmother, son, daughter, grandson, granddaughter, stepson, stepdaughter, brother, sister, half-brother, half-sister or a person in respect of whom an adoption order has been made." For the purposes of the present case and this particular statutory context we would be prepared to assume that Ms. Fleming's long-term partner, Mr. Curran, would come within the terms of this statutory definition.

**131.** When a similar office was being re-organised in the United Kingdom by the Prosecution of Offences Act 1985, that Act contained a specific statutory provision which required the Director in the United Kingdom to issue guidelines for Crown prosecutors. Section 10 of the Act of 1985, under the heading "Guidelines" provides:-

> "1. The Director shall issue a code for Crown prosecutors giving guidance on general principles to be applied by them –
>
> (a) in determining, in any case –
>
> (i) whether proceedings for an offence should be instituted or, where proceedings have been instituted, whether they should be discontinued;
>
> or
>
> (ii) what charges should be preferred; and
>
> (b) in considering, in any case, representations to be made by them to any magistrates about the mode of trial suitable for that case."

**132.** No such statutory obligation is devolved on the Director in this jurisdiction, although since 2001 prosecutorial guidelines have been issued and revised from time to time, the most recent being in 2010. These guidelines are general in nature, or, to put it another way, are non-offence specific and have no statutory force. The stated intention of the guidelines is to give general guidance to prosecutors so that a fair, reasoned and consistent policy underlies the prosecution process.

**133.** The introduction to the guidelines issued in November, 2010 states as follows:-

> "1.1 Fair and effective prosecution is essential to a properly functioning criminal justice system and to the maintenance of law and order. The individuals involved in a crime – the victim, the accused and the witnesses – as well as society as a whole have an interest in the decision whether to prosecute and for what offence, and in the outcome of the prosecution.
>
> 1.2 Every case is unique and must be considered on its own merits. For this reason there is no simple formula which can

be applied to give a simple answer to the questions the prosecutor has to face. But there are general principles which should underlie the approach to prosecutions, even though the individual facts of each case will require the prosecutor to use judgment and discretion in their application.

1.3 The aim of these guidelines for prosecutors is to set out in general terms principles which should guide the initiation and conduct of prosecutions in Ireland. They are not intended to override any more specific directions which may exist in relation to any particular matter. They are intended to give general guidance to prosecutors on the factors to be taken into account at the different stages of a prosecution, so that a fair, reasoned and consistent policy underlies the prosecution process.

1.4 The guidelines are not intended to and do not lay down any rule of law. Rules of law are made by the Oireachtas and the Courts. To the extent that there are existing rules of law which govern prosecution policy, the guidelines are intended to reflect those rules. The guidelines are not issued pursuant to any statutory duty or power."

**134.** Part 4 of the Guidelines addresses the issue "whether to prosecute" and in relevant part states as follows:-

"4.1 The decision to prosecute or not to prosecute is of great importance. It can have the most far reaching consequences for an individual. Even where an accused person is acquitted, the consequences resulting from a prosecution can include loss of reputation, disruption of personal relations, loss of employment and financial expense, in addition to the anxiety and trauma caused by being charged with a criminal offence. A wrong decision to prosecute or conversely, a wrong decision not to prosecute, both tend to undermine the confidence of the community in the criminal justice system. For victims and their families, a decision not to prosecute can be distressing. The victim, having made what is often a very difficult and occasionally traumatic decision to report a crime, may feel rejected and disbelieved.

4.2 It is therefore essential that the prosecution decision receives careful consideration. But, despite its important consequences for the individuals concerned, the decision is one which the prosecutor must make as objectively as possible."

**135.** Under the section dealing with "the Public Interest", the Guidelines state as follows:-

"4.4 As in other common law systems, a fundamental consideration when deciding whether to prosecute is whether to do so would be in the public interest. A prosecution should be initiated or continued, subject to the available evidence disclosing a *prima facie* case, if it is in the public interest, and not otherwise.

4.5 There are many factors which may have to be considered in deciding whether a prosecution is in the public interest. Often the public interest will be clear but in some cases there will be public interest factors both for and against prosecution.

4.6 There is a clear public interest in ensuring that crime is prosecuted and that the wrongdoer is convicted and punished. It follows from this that it will generally be in the public interest to prosecute a crime where there is sufficient evidence to justify doing so, unless there is some countervailing public interest reason not to prosecute. In practice, the prosecutor approaches each case first by asking whether the evidence is sufficiently strong to justify prosecuting. If the answer to that question is "no" then a prosecution will not be pursued. If the answer is "yes" then before deciding to prosecute the prosecutor will ask whether the public interest favours a prosecution or if there is any public interest reason not to prosecute.

4.7 In assessing whether the public interest lies in commencing or continuing with the prosecution, a prosecutor should exercise particular care whether there is information to suggest that the suspect is a victim of crime. An example would be where it is suggested that the suspect is a victim of human trafficking. Such a person may be suspected of a range of offences from breaches of immigration law to offences relating to prostitution. In a case in which there is credible information that a suspect is also a crime victim, the prosecutor should consider whether the public interest is served by a prosecution of the subject.

4.8 Factors which should be considered in assessing whether to commence or continue with the prosecution include (i) the relative seriousness of any offence allegedly committed by the suspect and of any offence of which the suspect is believed to be a victim, (ii) whether there is any information that coercion or duress was exercised against the suspect, (iii) where there are allegations that the suspect was subjected to duress whether it is alleged that this included violence or threats of violence or the use of force, deceit or fraud, or an abuse of authority or exploitation of a position of vulnerability, and (iv) whether the suspect has cooperated with the authorities in relation to any offences believed to have been committed against the suspect."

**136.** In addressing the issue as to whether there are cases where there may be a public interest reason not to prosecute, the guidelines states as follows:-

"4.18 Once the prosecutor is satisfied that there is sufficient evidence to justify the institution or continuance of a prosecution, the next consideration is whether, in the light of the provable facts and the whole of the surrounding circumstances, the public interest requires a prosecution to be pursued. <u>It is not the rule that all offences for which there is sufficient evidence must automatically be prosecuted.</u> (Emphasis added)

4.19 The factors which may properly be taken into account in deciding whether the public interest requires a prosecution will vary from case to case. As already stated the interest in seeing the wrongdoer convicted and punished and crime punished is itself a public interest consideration. The more serious the offence, and the stronger the evidence to support it, the less likely that some other factor will outweigh that interest. The first factor to consider in assessing where the public interest lies, is therefore, the seriousness of the alleged offence and whether there are any aggravating or mitigating factors."

**137.** There then follows a list of aggravating factors which, if present, tend to increase the likelihood that the public interest requires a prosecution. This list is followed by a list of mitigating factors, which, if present, tend to reduce the seriousness of the offence and hence the likelihood of a prosecution being required in the public interest. They include considerations of whether the court is likely to impose a very small or nominal penalty and whether the offence is a first offence and one unlikely to be repeated.

**138.** Part 4.22 of the guidelines proceeds to address "other matters which may arise when considering whether the public interest requires a prosecution" and, *inter alia*, includes the following:-

> "(a) the availability and efficacy of an alternative to prosecution,
>
> (b) the prevalence of offences of the nature of that alleged and the need for deterrent, both generally and in relation to the particular circumstances of the offender,
>
> (c) the need to maintain the rule of law and public confidence in the criminal justice system,
>
> (d) whether the consequences of a prosecution or a conviction would be disproportionately harsh or oppressive in the particular circumstances of the offender,
>
> (e) the attitude of the victim or the family of a victim of the alleged offence to a prosecution,
>
> (f) the likely effect on the victim or the family of a victim of a decision to prosecute or not to prosecute."

**139.** Part 4.23 states that:

> "the relevance of these, and other factors, and the weight to be attached to them, will depend on the particular circumstances of each case. Fairness and consistency are of particular importance. However, fairness need not mean weakness and consistency need not mean rigidity. The criteria for the exercise of the discretion not to prosecute on public interest grounds can not be reduced to something akin to a mathematical formula; indeed it would be undesirable to attempt to do so. The breadth of the factors to be considered in exercising this discretion reflects the need to apply general principles to individual cases."

**140.** By letter dated 28th August, 2012 the solicitors acting on behalf of the plaintiff wrote to the Director indicating that the plaintiff felt strongly that her life would soon be unbearable and that she would wish to terminate it. The letter pointed out that she could not do so without assistance and that her partner, Mr. Tom Curran, had promised her that, subject to matters detailed in the letter, he would be willing to help her if she decided the time had come to die.

**141.** The letter then stated:-

> "As you are aware, section 2, subsection (2) of the Act of 1993 makes it an offence, *inter alia*, to aid or abet the suicide of another while subsection (4) prohibits prosecutions under the section without the consent of your office. Our client's difficulty is that they are unaware of the principles or guidelines or policies that may be adopted or followed by your office in deciding, in particular cases, whether to prosecute or consent to the prosecution of a person who assists someone in Ms. Fleming's position in procuring her own death. As a result, Mr. Curran cannot know whether or not in assisting Ms. Fleming in any particular way or at any particular stage of her disease, he will be exposed to prosecution.
>
> In *Regina (Purdy) v. DPP* [2010] 1 A.C 345, the Judicial Committee of the House of Lords ruled that the lack of a published policy of the (U.K.) Director in relation to prosecutions under equivalent provisions of U.K. law rendered the relevant law insufficiently clear, accessible and precise to permit a person potentially affected by it to know the degree to which it would affect his or her actions and that this amounted to an unjustified intrusion into the private life of a person in a very similar position to that of her client. The Committee ruled, in particular, that in those circumstances, the existing law and code of prosecution failed to meet the requirements for clarity imposed in respect of any such intrusion, by Article 8 (2) of the schedule to the Human Rights Act 1998 (U.K.), that is Article 8 (2) of the European Convention on Human Rights. The Committee ruled that the DPP should adopt and publish an offence specific policy identifying the facts and circumstances that would be taken into account in deciding whether or not prosecute such an offence.
>
> We have advised our clients that similar arguments to those advanced by Ms. Purdy in the U.K. are available to them in this jurisdiction if no clear policy is available that would allow Mr. Curran (and Ms. Fleming) to know whether or not and in what circumstances Mr. Curran might be prosecuted for assisting Ms. Fleming in terminating her life. A key factor is that Ms. Fleming may be denied the right or power to end her life by the lack of clarity as to the circumstances in which a person who assists her might be prosecuted under s. 2 of the Act of 1993.
>
> In those circumstances, the purpose of this letter is to ask you whether or not any policy has been or is about to be adopted by your office in relation to the prosecution of offences under s. 2 of the Criminal Law (Suicide) Act 1993 and, if so, to publish, at the very least to our clients, the terms of that policy.
>
> Please note that unless a policy is made known to our clients that would allow Ms. Fleming to receive assistance, in her very unusual and compelling circumstances, in terminating her own life without the person rendering assistance being exposed to prosecution, our clients intend to issue proceedings before the High Court requiring that such a policy, in terms that would remove the fear of prosecution for a person in Mr. Curran's position (subject to suitable safeguards), should be published in very early course and, in the alternative, seeking to strike down as unconstitutional the terms of s. 2 of the Act of 1993 on the grounds, broadly, that in failing to make any allowance for persons in the position of our clients, the provision unjustifiably discriminates against them, breaches their rights to privacy and autonomy and lacks proportionality."

**142.** By letter dated 3rd October, 2012 the Director replied to this letter in the following terms:-

> "The Director is very sorry to hear of Ms. Fleming's illness and can only try to image the immense difficulties which this causes for her and her partner.
>
> The Director has very carefully considered the request contained in your letter and has obtained the advices of senior counsel.
>
> The Directors notes the reference in your letter to the English Supreme Court decision of *Regina (Purdy) v. DPP* [2010] 1.A.C 345. However, there is no provision in Irish law equivalent to s. 10 of the Prosecution of Offences Act 1985 in England and Wales, which requires that Director to issue a code for prosecutors giving guidance on the general principles to be applied on prosecutorial decision making. There is therefore no statutory duty on the Director of issue guidelines in

this jurisdiction. The former Director did promulgate guidelines which have been adopted by the current Director. They are available on our website: www.dppireland.ie. Although they are not statutory guidelines the Director can confirm that they would guide any prosecutorial decision making made by her or her professional officers.

Section 2 (4) of the Criminal Law (Suicide) Act 1993 provides that no proceedings shall be instituted for an offence under this section except by or with the consent of the Director. The Director believes that this requires her *ex post facto* to evaluate the public interest in bringing criminal proceedings in each case which arises. Any decision in relation to any such case would of course be taken in accordance with our published guidelines.

The Director has not issued any guidelines of the kind mentioned in your letter of 28th August, 2012. Having considered the matter carefully the Director has decided that she will not publish any such guidelines and that decisions as to whether there should be a prosecution under s. 2 of the Criminal Law (Suicide) Act 1993 will be decided on the basis of the facts of any individual case. Furthermore, the Director believes that there are significant legal impediments to her publishing guidelines of the type requested in your letter having regard to the constitutional separation of powers and the roles designated to the Oireachtas and the courts under the Constitution. Subject to any guidance or direction that the Superior Courts might give her, she does not believe that it would be appropriate for her to issue any such guidelines."

**143.** The plaintiff's submissions on the requirement to issue guidelines are largely dependent, if not actually derived from, the decision of the House of Lords in the case of *R. (Purdy) v. Director of Public Prosecutions* [2010] 1 A.C. 435 wherein the House of Lords held that the right to respect for private life in Article 8 (1) of the European Convention on Human Rights was engaged by the facts of Ms. Purdy's case such as to protect her right to make an informed decision about the time and manner of her death and that such entitlement had been violated by the refusal of the U.K. DPP to publish the criteria according to which he might determine whether or not to prosecute a case of assisted suicide in the public interest. As a result of the decision in the *Purdy* case, the Crown Prosecution Service published a "policy for prosecutors in respect of cases of encouraging or assisting suicide" which gave express guidance on the public interest factors to be weighed in the balance for or against prosecution.

**144.** While these guidelines will be referred to again later, at this point the Court will address itself to the plaintiff's submissions which were based on the premise that there was no good reason for any different form of direction or order in the Irish courts. Emphasising that the plaintiff was not seeking either a "letter of comfort" or a dispensation in the case of Mr. Curran from any possibility of prosecution, it was contended that the plaintiff and her partner were nonetheless entitled to know the factors which might influence the Director in her decision whether or not to prosecute Mr. Curran if he assisted the plaintiff in committing suicide. It was contended that this was a need and requirement based on the Convention tests of accessibility and foreseeability. Baroness Hale in the *Purdy* case had identified the requirement that people should know where they stood when it comes to the criminal law stating (at para. 59):-

> "… (a) major objective of the criminal law is to warn people that if they behave in a way which it prohibits they are liable to prosecution and punishment. People need and are entitled to be warned in advance so that, if they are of a law abiding persuasion, they can behave accordingly."

**145.** While acknowledging that the European Convention on Human Rights does not operate as a free standing part of Irish law, it was contended on behalf of the plaintiff that the manner in which the Convention was applied in the *Purdy* case should apply in precisely the same way in Ireland under and by virtue of s. 3 (1) of the Human Rights Act 2003 which obliges an organ of the State to carry out its functions in a manner compatible with the requirements of the Convention unless constrained by Statute or rule of law.

**146.** There could be no doubt, and indeed it was common case, that the Office of the Director of Public Prosecutions was an "organ of the State" and it was contended on behalf of the plaintiff that the reference in s. 3 (1) which requires every organ of the State to perform its functions in a manner compatible with the State's obligations under the Convention provisions must be deemed to include the function of issuing guidelines. Thus it fell to the Director to exercise her discretion whether or not to prosecute in a manner compatible with Article 8 of the Convention as interpreted in the *Purdy* decision. It was thus argued that the failure to bring forward such guidelines intruded to an unnecessary extent on the plaintiff's right to privacy and to no reasonable or compelling purpose. On the contrary, it was unusual that a criminal provision should infringe the rights of those protected and for the class of those protected of whom the plaintiff happened to belong.

**147.** The plaintiff accepted, however, that even if the Director published fulsome guidelines, there would remain the possibility that the Director could still elect to prosecute any given case. It was further accepted that whatever powers the Director might have, they could not have the effect of overriding the intention of the Oireachtas or offending the separation of powers principles inherent in Article 15.2 of the Constitution.

**148.** On behalf of the Director it was submitted that the Director would be "aiding a crime" if she were to grant the plaintiff's request to outline the factors that would be considered when deciding whether or not to prosecute for assisted suicide. Any such guidelines would constitute a "road map" under which a person might more safely commit a crime and avoid prosecution.

**149.** It was argued that the Director has no power to adopt a policy that she will not prosecute in certain cases. The Director was, in effect being asked to legislate in a way that was quite impermissible under both the Prosecution of Offences Act 1974 and, more particularly, the Constitution.

**150.** Even if the logic of the *Purdy* decision was applied and the Director was obliged to exercise her powers, there is no express power conferred on the Director to do what was ordered in the United Kingdom. On the contrary, it would amount to forcing her into adopting a role which would in effect override statutory measures laid down by the Oireachtas. The Prosecution of Offences Act 1974 contains no provision analogous to s. 10 of the English Act of 1985.

**151.** The Director exercises a discretion *ex post facto* in relation to the facts of any incidents brought to her notice. Guidelines for prosecutors do not and can not provide for offence specific criteria referable to the decision to prosecute. Only under s. 8 (4) of the Garda Síochána Act 2005 had the Director been empowered to "give, vary or rescind directions concerning the institution and conduct of prosecutions by members of the Garda Síochána". Clearly it was beyond the principles and policies contained in that Act to suggest that similar directions could be given under the section by the Director which relate to anything other than that which had been provided for in the particular Act. The mere fact that such a power had been expressly conferred by statute in this one instance was strongly suggestive of the fact that, absent some such express provision conferred by the legislature, the Director had no such power.

**152.** The issuance of general guidelines on a voluntary basis by the Director could not be seen as the discharge of a "power or duty"

as the term "functions" had been defined in the Act of 1974. Section 3 (1) of the European Convention of Human Rights Act 2003 did not provide a basis for the plaintiff to invoke the application of the Convention to a matter such as the issuance of guidelines. The function of Director as provided for in legislation and under Article 30.3 of the Constitution does not include a legislative or quasi-legislative function. The Director had only been given a power to prosecute and a discretion whether or not to prosecute in any given case and that discretion can only be exercised *ex post facto*. Section 3 (1) of the Human Rights Act 2003 does not purport to create functions to be exercised by organs of the State but merely describes the manner in which functions elsewhere given are to be exercised. Therefore an obligation to make guidelines as argued for by the plaintiff could not be rooted in s. 3 (1) of the 2003 Act. Furthermore, any obligation on an organ of State placed by s. 3 (1) is expressed to be subject to "any statutory provision (other than this Act) or rule of law". A non-exhaustive list of statutes and rules which would exclude a requirement to make guidelines would include:-

(a) Article 15.2 of the Constitution

(b) Article 30.3 of the Constitution

(c) The Prosecution of Offences Act 1974

(d) The Criminal Law (Suicide) Act 1993.

**153.** In marked contrast to s. 3 (1) of the Irish Human Rights Act of 2003, the United Kingdom Human Rights Act 1998 requires a Court there to consider if a Convention right has been impaired and provides for a duty on public bodies to act in accordance with Convention rights. That measure was far broader in scope than the Irish s. 3 (1) which is confined to organs of State acting in the performance of their functions. Thus s. 6 of the United Kingdom Act has no counterpart in the Irish Act and the decision in *Purdy* can not be seen as a persuasive authority in this jurisdiction. The Convention must at all times in this jurisdiction be viewed through the prism of the Act of 2003.

**154.** The sole and exclusive power to make laws in this jurisdiction, regulated as it is by its written Constitution, is conferred by Article 15.2 on the Oireachtas. While it may, in turn, permit the making of limited subordinate legislation by bodies other than the Oireachtas itself, no such power had been conferred in this case on the Director of Public Prosecutions and no such power therefore exists.

**155.** In discussion between members of the Court and counsel for the Director, it was readily acknowledged and accepted on behalf of the Director that the predicament of the plaintiff was a truly appalling one and the Director was acutely conscious of her tragic circumstances.

**156.** While the Director could not, in advance of an act of assisted suicide, give any undertaking or indication as to whether or not a prosecution would follow the occurrence of such an act, a communication with the Director either by the person who intended to commit suicide or by a member of her family, was not precluded under the 1974 Act. Asked what the Director's attitude might be if the plaintiff or a member of her family were to submit a file indicating, for example, that all of the factors outlined in guidelines introduced in the U.K. following the *Purdy* decision had been complied with in advance of a proposed assisted suicide, counsel for the Director said that such a course would be legally permissible. It would, however, put the Director on notice of an intended criminal offence such that the Director might feel obliged to communicate with some other authority so as to ensure that a criminal offence, which at that point in time might be preventable, did not occur.

**157.** On further questioning by members of the Court, it was confirmed by counsel on behalf of the Director that she would on the other hand be necessarily obliged to give very careful consideration *ex post facto* to documentation which clearly established that factors such as those outlined in the prosecutor's guidelines in the United Kingdom had been observed in a particular case under consideration. It was correct to say that the Director could, and indeed was obliged, to take into account all relevant considerations when exercising her discretion. This view of the Director's role was also shared by counsel for the State. Both agreed that such a course would undoubtedly greatly narrow down the risk of any *ex post facto* prosecution.

**158.** The Court is satisfied that the decision in the *Purdy* case has limited relevance in this jurisdiction in the context of the question as to whether this Court can or should direct the DPP to issue guidelines on assisted suicide. This position derives in the first instance from the fact that the Constitution in this jurisdiction is a written one with express provisions providing for law-making by the legislature which can not be usurped by the courts and derives further from the different ways in which the European Convention on Human Rights has been incorporated in the domestic law of the two jurisdictions.

**159.** In the United Kingdom, the Human Rights Act 1998 by s. 1 provided, that Articles 2-12 of the Convention "are to have effect for the purposes of this Act subject to any designated derogation or reservation". The requirement to consider whether rights guaranteed by the Convention have been impaired devolve on the courts under s.2 in a much more direct way than in this jurisdiction where the Convention was incorporated in a particular manner into our domestic law at a sub-constitutional level. Section 6 of the U.K. Act makes it "unlawful" for a public authority to act in a way that is incompatible with a Convention right and proceedings may be brought against such an authority by a person claiming to be a victim of the unlawful act and relying on his right under the Convention. This section applies to the courts in the U.K. whereas in this jurisdiction courts are specifically excluded from the definition of "organ of the State".

**160.** In this jurisdiction the European Convention on Human Rights Act 2003 provides as follows:-

> "2.(1) In interpreting and applying any statutory provision or rule of law, a court shall, insofar as is possible, subject to the rules of law relating to such interpretation and application, do so in a manner compatible with the State's obligations under the Convention provisions.
>
> (2) This section applies to any statutory provision or rule of law in force immediately before the passing of this Act or any such provision coming into force thereafter.
>
> 3.(1) Subject to any statutory provision (other than this Act) or rule of law, every organ of the State shall perform its functions in a manner compatible with the State's obligations under the Convention provisions.
>
> (2) A person who has suffered injury, loss or damage as a result of a contravention of subsection (1) may, if no other remedy in damages is available, institute proceedings to recover damages in respect of the contravention in the High Court and the court may award to the person such damages (if any) as it considers appropriate."

**161.** Putting it in simple terms, the Convention does not have direct effect in this jurisdiction. The form of incorporation in Ireland does no more than require, at a sub-constitutional level, that a court shall "insofar as is possible, subject to the rules of law relating to such interpretation and application" interpret a statutory provision or rule of law in a manner compatible with the Convention.

**162.** There must therefore be a statute or rule of law to which Convention principles may be said to attach. The Convention does not operate in a free standing way, nor can it override the provisions of the Constitution. Further, in interpreting or applying such provision or rule of law, the court is necessarily circumscribed by existing rules of law relating to such interpretation and application.

**163.** Thus in *MD (Minor) v. Ireland, AG & DPP* [2012] IESC 10, [2012] 2 I.L.R.M. 305 where the appellant had included in his claim an assertion that s.3 of the Criminal Law (Sexual Offences) Act 2006 was "in breach" of certain articles of the Convention, Denham C.J. stated ([2012] 2 I.L.R.M. 305, 324):-

> "That formulation is not acceptable. It treats the Convention as if it had direct effect and presumes that the Court has the power to grant a declaration that a section is in breach of the Convention. It is clear from the judgments of this Court in *McD v. L* [2010] 2 I.R. 199 that the European Convention on Human Rights Act 2003 did not give direct effect in Irish law to the European Convention on Human Rights. As Murray C.J. stated at page 248, 'The Convention does not of itself provide a remedy at national level for victims whose rights have been breached by reference to the provisions of the Convention'"

**164.** Quite clearly it would be impermissible for any court in this jurisdiction to apply a Convention principle when to do so would bring the court into conflict with the rule of law as prescribed by the Constitution and, in particular, Article 15.2 thereof which provides:

> "1. The sole and exclusive power of making laws for the State is hereby vested in the Oireachtas ... no other legislative authority has power to make laws for the State.
>
> 2. Provision may however be made by law for the creation or recognition of subordinate legislatures and for the powers and functions of these legislatures."

**165.** The rule of law implies that the Director is generally expected to apply the law of the land, as it is understood to be. Thus, the Director is not entitled to refuse to consider a prosecution within a particular class, whatever the individual circumstances. The Director can not indirectly rewrite the law without encroaching upon Article 15.2 of the Constitution.

**166.** It seems clear to this Court that the effect of any direction requiring the Director to issue guidelines of the kind now sought by the plaintiff would infringe these basic constitutional principles. While the plaintiff asserts that she is seeking no more than a statement of factors which would influence the decision of the Director whether or not to prosecute, the reality of course is that, for her own very good reasons, she wishes to know that the Director will not in fact prosecute in her case. Whatever the stated objective of seeking guidelines may be, there can be no doubt but that the intended *effect* of obtaining such relief would be to permit an assisted suicide without fear of prosecution. No amount of forensic legerdemain can alter that fact. For, absent such *effect*, one is driven to ask what practical purpose or value lies in seeking such guidance? There is, in truth, none. It follows therefore that in this context 'effect' is every bit as important as 'object'. It is no mere coincidence that "object or effect" criteria are commonly referred to in descriptions of offences under the Competition Act 2002, notably for offences involving cartels or anti-competitive behaviour by undertakings. Once guidelines may be characterised as having the effect of outruling a prosecution, they must be seen as altering the existing law and must therefore fall foul of Article 15.2 of the Constitution. These considerations also outrule the suggestion made by Professor Battin that some form of dialogue or consultation with prosecutorial authorities in advance of an assisted suicide might be of value. In the Court's view the extent to which Article 8 of the Convention is engaged is a matter falling within the constitutional argument in the first part of this case and not this part of the case at all.

**167.** Within our domestic law no provision exists in the Act of 1974 which mandates or directs the Director to issue guidelines. Such guidelines as have been issued by the Director from time to time have no statutory basis. Indeed the very insertion of s. 10 in the English Act is indicative that, absent such a provision, the Director can not be considered as part of her functions, to have any such power.

**168.** While the Court thus concludes that it should not direct that the Director issue offence-specific guidelines in relation to assisted suicide, the decision in *Purdy* is nonetheless one of significant value. It led to the introduction by the Director in the United Kingdom of offence-specific guidelines for assisted suicide in that jurisdiction. Because we share a similar system for the initiation of criminal proceedings the Court believes that those guidelines provide considerable assistance to the Director here if an event of assisted suicide were to occur. That is particularly so when the wording of the offence in the Suicide Act 1961 is virtually identical to that of our own Criminal Law (Suicide) Act, 1993.

**169.** That the nature of the discretion of the Director is similar in both jurisdictions is also clear. The discretion is not focused exclusively on evidential matters in either jurisdiction. There is no automatic prosecution based on evidence alone. Thus in *Smedleys Ltd v. Breed* [1974] A.C. 839, Viscount Dilhorne said:-

> "In 1951 the question was raised whether it was not a basic principle of the rule of law that the operation of the law is automatic where an offence is known or suspected. The then Attorney General, Sir Hartley Shawcross, said: 'It has never been the rule in this country – I hope it never will be – that criminal offences must automatically be the subject of prosecution.' He pointed out that the Attorney General and the Director of Public Prosecutions only intervene to direct a prosecution when they consider it in the public interest to do so and he cited a statement made by Lord Simon in 1925 when he said: '…there is no greater nonsense talked about the Attorney General's duty than the suggestion that in all cases the Attorney General ought to decide to prosecute merely because he thinks there is what the lawyers call a case. It is not true and no one who has held the office of Attorney General supposes it is.' Sir Hartley Shawcross's statement was indorsed, I think, by more than one of his successors."

**170.** This overview of the Director's role was again confirmed by the House of Lords in the Purdy case. To similar effect in this jurisdiction, Finlay C.J. in *The State (McCormack) v. Curran* [1987] I.L.R.M. 225 stated at p 237:-

> "In regard to the DPP I reject also the submission that he has only got a discretion as to whether to prosecute or not to prosecute in any particular case related exclusively to the probative value of the evidence laid before him. Again, I am satisfied that there are many other factors which may be appropriate and proper for him to take into consideration." (Emphasis added)

**171.** The very fact that UK guidelines on assisted suicide now exist must surely inform any exercise of discretion by the Director in this jurisdiction. Without being compelled in an impermissible way under our law to issue offence-specific guidelines, the Director in this jurisdiction is nonetheless in as good a position as the Director in the U.K as an incidental beneficiary of what happened in that jurisdiction. Because of their importance in the overall context of this part of the case the Court believes those guidelines should be set out in some detail. In relevant part they read as follows:-

"43. A prosecution is more likely to be required if:

1. the victim was under 18 years of age;

2. the victim did not have the capacity (as defined by the Mental Capacity Act 2005) to reach an informed decision to commit suicide;

3. the victim had not reached a voluntary, clear, settled and informed decision to commit suicide;

4. the victim had not clearly and unequivocally communicated his or her decision to commit suicide to the suspect;

5. the victim did not seek the encouragement or assistance of the suspect personally or on his or her own initiative;

6. the suspect was not wholly motivated by compassion; for example, the suspect was motivated by the prospect that he or she or a person closely connected to him or her stood to gain in some way from the death of the victim;

7. the suspect pressured the victim to commit suicide;

8. the suspect did not take reasonable steps to ensure that any other person had not pressured the victim to commit suicide;

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

10. the victim was physically able to undertake the act that constituted the assistance him or herself; (*sic*)

11. the suspect was unknown to the victim and encouraged or assisted the victim to commit or attempt to commit suicide [by] providing specific information via, for example, a website or publication;

12. the suspect gave encouragement or assistance to more than one victim who were not known to each other;

13. the suspect was paid by the victim or those close to the victim for his or her encouragement or assistance;

14. the suspect was acting in his or capacity as a medical doctor, nurse, other healthcare professional, a professional carer (whether for payment or not), or as a person in authority, such as a prison officer, and the victim was in his or her care;

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;

16. the suspect was acting in his or her capacity as a person involved in the management or as an employee (whether for payment or not) of an organisation or group, a purpose of which is to provide a physical environment (whether for payment or not) in which to allow another to commit suicide.

(44). On the question of whether a person stood to gain, (para. 43(6) see above), the police and the reviewing prosecutor should adopt a common sense approach. It is possible that the suspect may gain some benefit – financial or otherwise – from the resultant suicide of the victim after his or her act of encouragement or assistance. The critical element is the motive behind the suspect's act. If it is shown that compassion was the only driving force behind his or her actions, the fact that the suspect may have gained some benefit will not usually be treated as a factor tending in favour of prosecution. However, each case must be considered on its own merits and on its own facts.

**Public interest factors tending against prosecution**

(45). A prosecution is less likely to be required if:

1. the victim had reached a voluntary, clear, settled and informed decision to commit suicide;

2. the suspect was wholly motivated by compassion;

3. the actions of the suspect, although sufficient to come within the definition of the offence, were of only minor encouragement or assistance;

4. the suspect had sought to dissuade the victim from taking the course of action which resulted in his or her suicide;

5. the actions of the suspect may be characterised as reluctant encouragement or assistance in the face of a determined wish on the part of the victim to commit suicide;

6. the suspect reported the victim's suicide to the police and fully assisted them in their enquiries into the circumstances of the suicide or the attempt and his or her part in providing encouragement or assistance.

(46). The evidence to support these factors must be sufficiently close in time to the encouragement or assistance to allow the prosecutor reasonably to infer that the factors remained operative at that time. This is particularly important at the start of the specific chain of events that immediately led to the suicide or the attempt.

(47). These lists of public interest factors are not exhaustive and each case must be considered on its own facts and on its own merits.

(48). If the course of conduct goes beyond encouraging or assisting suicide, for example, because the suspect goes on to take or attempt to take the life of the victim the public interest factors tending in favour of or against prosecution may have to be evaluated differently in the light of the overall criminal conduct."

**172.** A similar list of factors was identified in the Canadian case of *Carter v. Canada* [2012] BCSC 886. Those factors, to the extent that they add value to the exercise of the Director's discretion, may also be taken into account by her in this jurisdiction.

**173.** If due regard is given to these factors – and no reason has been advanced to suggest the essential factors would be any different in this jurisdiction – it is clear that the Director would have extensive material to provides guidance whether or not to prosecute in a given case. That this is the desideratum is clear from views expressed by the European Court of Human Rights in *Pretty v. United Kingdom* (2002) 35 EHRR 1 (at paras. 76-77):-

"76. ….It does not appear to be arbitrary to the Court for the law to reflect the importance of the right to life, by prohibiting assisted suicide while providing for a system of enforcement and adjudication which allows due regard to be given in each particular case to the public interest in bringing a prosecution, as well as to the fair and proper requirements of retribution and deterrence.

77. Nor in the circumstances is there anything disproportionate in the refusal of the DPP to give an advance undertaking that no prosecution would be brought against the applicant's husband. Strong arguments based on the rule of law could be raised against any claim by the executive to exempt individuals or classes of individuals from the operation of the law. In any event, the seriousness of the act for which immunity was claimed was such that the decision of the DPP to refuse the undertaking sought in the present case cannot be said to be arbitrary or unreasonable."

**174.** Most, if not all, of the difficulties in this case, insofar as they relate to the issue of guidelines, derives from the fact that it is sought to require the Director to issue offence-specific guidelines in advance of the event which might trigger a prosecution. The Court has detailed the various reasons why it believes that this is impermissible under Irish law, and the Court accepts the submissions advanced on behalf of the Director that to apprise her of an intention to commit a criminal act in advance may place her in an invidious, if not impossible, position. To be made aware of an intended criminal offence might well, as outlined by counsel for the Director, oblige the Director to consult and liaise with other public authorities with a view to restraining the commission of an offence such as occurred in the "X" case in this country in 1992 (*Attorney General v. X* [1992] 1 I.R. 1). This objection is one not lightly to be discounted.

**175.** However, a different state of affairs arises where reliable evidence of compliance with a list of factors, such as those specified in the U.K. Prosecutors guidelines, is presented to the Director *ex post facto* the event. She is then free to apply her discretion and make a fully informed decision as to whether or not to initiate a prosecution. This is not, of course, to suggest that every day decisions emanating from the Director's office are not fully informed, but in the unique and special circumstances surrounding the harrowing experiences being endured by the plaintiff and her partner, the fact, as her counsel has confirmed to this Court, that full and careful consideration would have to be given to evidence of compliance with a list of factors such as those that followed the *Purdy* case provides a measure of comfort. The Court feels sure that the Director, in this of all cases, would exercise her discretion in a humane and sensitive fashion, while it would stress that, of course, she must retain the full ambit of that discretion to decide whether to prosecute or not. The timing or sequencing involved in this approach leaves intact the legislative framework which underlines and upholds the pre-eminent right to life as enshrined in the Constitution while at the same time it avoids placing the Director in what for her would be an impossible situation. It also protects against the "slippery slope" dangers identified in all of the cases whereby elderly or ill persons might be induced or otherwise coaxed or manipulated into seeking prematurely to terminate their own lives. Section 2 of the Act of 1993 would thereby preserve its deterrent effect.