



HALSBURY'S LAW EXCHANGE

**A Critical Consideration of the
Director of Public Prosecutions
Guidelines in Relation to Assisted
Suicide Prosecutions and their
Application to the Law**

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Executive Summary

The Suicide Act 1961 changed the law under which it had been a crime for a person to commit suicide.

Assisted suicide remains illegal under s 2 of the Act. Whilst a person may refuse medical treatment even though that refusal would result in her death, she cannot ask another to take her life or assist her in doing so without exposing that person to a criminal prosecution.

Following the House of Lords' judgment in the *Debbie Purdy* case, the Director of Public Prosecution (DPP) issued guidelines on the circumstances in which he will exercise his discretion to bring a prosecution in the case of what appears to be an assisted suicide.

The guidelines are set out in full in the paper. They are not exhaustive, and do not change the law - assisting suicide remain illegal. They do fetter the DPP's discretion not to prosecute, but the DPP has always been reluctant to prosecute, and will continue to be so.

A more immediate impact of the guidelines concerns the distinct area of professional medical involvement as an aggravating feature - this will make the medical profession far more wary of administering assistance which could be interpreted as assisting suicide.

In many respects the guidelines go much further than the House of Lords postulated. But it is important that the guidelines are seen in the context of the general law as developed over many years of legal jurisprudence.

Time will tell how well they survive analysis at the coalface of the courtroom, although, given that historically there have been few prosecutions, it may be some time before the guidelines are rigorously tested.

There remain problematic aspects, but provided that the aggravating and mitigating factors enunciated by the DPP are interpreted in accordance with the unchanged law, the guidelines can enhance and maintain the existing law.

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SUICIDE

The Suicide Act 1961, s 1, abrogated the rule of law whereby it was a crime for a person to commit suicide. It had been considered a felony at common law for a sane person of the age of responsibility to kill themselves either intentionally or in the course of trying to kill another. As a matter of legal history, such a suicide was regarded as self-murder. Although the offender was, in the nature of things, personally beyond the reach of the law, their guilt was not without important consequences at common law, since it resulted in the forfeiture of the deceased's property. The results were more important, however, where the attempt failed, for then, since the individual had attempted to commit a felony, he was guilty under ordinary common law principles of the misdemeanour of attempted suicide. If the unfortunate defendant in the course of trying to kill himself killed another, he was guilty of murder under the doctrine of transferred malice. Though suicide was regarded as "not a very serious crime"¹, an intention to commit it reflected the *mens rea* or mental intent of murder.

As a result of the Suicide Act 1961, s 1, which removed suicide from the criminal calendar, it followed that attempted suicide also ceased to be criminal and that there was no place for the doctrine of transferred malice where the defendant killed another in the course of trying to kill himself, for there was no malice to transfer.² That old jurisprudence continues to influence the way the law treats assisted suicide.

THE LAW IN RELATION TO ASSISTED SUICIDE

In *R: B (Consent to Treatment: Capacity)*³ a competent adult sought a declaration from the court that she was entitled to refuse medical treatment even though that refusal would result in her death. The court held that she had a right to do so. The position in which Ms B found herself in was one of demanding her right to take her own life.

But where a person is unable to take their own life, through for example disability or incapacity, an entirely different set of principles will apply. That person cannot ask another to take their life or take steps which would result in the extinguishment of their life without exposing that other person to the risk of criminal sanctions.

The Suicide Act 1961, s 2, laid down the following:

"Section 2(1): A person who aids, abets, counsels or procures the suicide of another, or an attempt by another to commit suicide, shall be liable on conviction on indictment to imprisonment for a term not exceeding 14 years.

Section 2(2): If on the trial of an indictment for murder or manslaughter it is proved that the accused aided, abetted, counselled or procured the suicide of the person in question, the jury may find him guilty of that offence...

Section 2(4): No proceedings shall be instituted for an offence under this Section except by or with the consent of the Director of Public Prosecutions."

As to sentencing, in the case of *R v Sweeney*⁴ Lord Justice Watkins observed that it was the policy of the law that even desperate people had to be deterred from taking life. The position was developed in the case of *R v Hough*⁵ wherein Lord Lane stated that the crime of assisted

suicide could vary from “the borders of cold blooded murder down to the shadowy area of mercy killing or common humanity.” In that case a nine month prison term was upheld on a 60-year-old woman of unblemished character who had been a regular visitor to an 84-year-old woman who was partly blind, partly deaf and suffered from arthritis. The elderly lady had persisted in various statements to the effect that she intended to take her own life, and the offender eventually supplied her with the necessary tablets. When she became unconscious, the offender placed a plastic bag over her head.

A further indication of the courts’ approach to sentencing in these matters can be gleaned from the authority of *R v Wallis*⁶ in which a sentence of 12 months imprisonment was described by the Court of Appeal as “the extreme of leniency”, in a case where the offender pleaded guilty to aiding the suicide of a 17-year-old flatmate by buying her tablets and alcohol, sitting with her while she took the tablets, and not calling the ambulance until she died.

As a matter of law, an individual can be criminally liable even if the person encouraged does not in fact commit or attempt to commit suicide. The offence is best categorised as Incitement to Commit Suicide.⁷ Presence is unnecessary for aiding, abetting or counselling particularly where the tools or materials for the suicide are supplied so far as mental intent is concerned, the important requirement is not presence so much, as encouragement,⁹ knowledge of an intention to commit the crime combined with something done to help in the commission of it has been held to be sufficient to commit the offence.¹⁰ But knowledge of the precise details of the commission of the offence is not necessary.¹¹

In the case of *Diane Pretty*¹² the European Court ruled that the Suicide Act 1961, s 2(1), was not disproportionate. In coming to that conclusion the court accepted the arguments of the UK Government that flexibility was provided for in individual cases by the fact that consent was needed from the Director of Public Prosecutions (DPP) to bring a prosecution. Furthermore, the fact that a maximum sentence was provided for, allowing lesser penalties to be imposed in the circumstances of the case, led the European Court to conclude that the legislation was proportionate.

THE REQUIREMENTS OF THE OFFENCE

The law surrounding assisted suicide was clarified in *Attorney General v Able*.¹³ The defendants were members of the Executive Committee of the Voluntary Euthanasia Society. They published a booklet entitled “A Guide to Self-Deliverance” for distribution to members of the Society. Subject to certain qualifications, the expressed aim of the booklet was to overcome the fear of the process of dying. While the booklet could deter a would-be suicide, it could also assist persons to commit suicide who might not otherwise do so. Indeed, it set out five separate methods of suicide.¹⁴

The introduction in the booklet articulated the views of some members of the Society as to their rights to control the manner and timing of their death. The introduction commences:

“The reasons for writing this pamphlet are quite simple. Those who join ‘Exit’ do so because they believe they have a right to a say in the manner and timing of their death, particularly if it seems likely that the process of dying will be a long one and distressing either to them or to their friends and families. For some the main fear will be of continuing pain, while for

others the main fear is of paralysis of body or mind or simply weariness with a life that has deteriorated beyond repair.”

In the case of *Able*, Mr Justice Woolf laid down three requirements that were necessary as a bare minimum before the crime of assisted suicide could be made out. They were that the conduct of an alleged accessory to suicide should indicate:

- (i) That the accused knew that the suicide was contemplated;
- (ii) That the accused approved of or assented to it; and
- (iii) That the accused attitude in respect of the potential suicide in fact encouraged the principal offender to perform (or attempt to perform) the suicide.

PRIOR CONSIDERATIONS FOR REFORM

In 1976, the Criminal Law Revision Committee made a proposal in a Working Paper that consideration should be given to the creation of a new offence of mercy killing. It was proposed that a person who unlawfully killed another should not be guilty of murder or of manslaughter but guilty of an offence punishable with two years' imprisonment if he, from compassion, killed another person who was, or was with reasonable cause, believed to be:

- (i) subject to great bodily pain or suffering; or
- (ii) permanently helpless from bodily or mental capacity; or
- (iii) subject to rapid and incurable bodily or mental degeneration.

This proposal received a hostile reception and the Criminal Law Revision Committee were persuaded that the public were not prepared to countenance what was seen as a threat to the sanctity of life. When they published their reports the proposal was abandoned.

The Law Commission submitted a different proposal to the Select Committee on Murder and Life Imprisonment where it agreed that there should be no separate offence for mercy killing, but that some cases might be covered by a new special defence reducing murder to manslaughter. In 1988 the Law Commission stated that:

“The limits of the defence might be:

- a. That the killing was done in order to relieve a person who was permanently subject to great bodily pain or suffering, or permanently helpless from bodily or mental incapacity or subject to rapid and incurable mental or bodily degeneration; and
- b. At a time when the accused was affected by severe emotional distress.”

The Law Commission pointed out that such a defence would not excuse a doctor or nurse from liability to conviction of murder and that it would be wrong for the law to appear to be sanctioning such killings by “Professionals”. This, in effect, would amount to an extension of the defence of diminished responsibility, explicitly bringing within that defence some cases which at present are accommodated only by a straining of the concepts beyond their proper limits and others where the defendant is not so fortunate and is convicted of murder.

The British Medical Association's Working Party on Euthanasia in 1988 concluded that:

“An active intervention by anybody to terminate another person's life should remain illegal.

Neither doctors nor any other occupational group should be placed in a category which lessens their responsibilities for their actions... the law should not be changed and the deliberate taking of a human life should remain a crime. This rejection of a change in the law to permit doctors to intervene to end a person's life is not just a subordination of individual wellbeing to social policy. It is, instead, an affirmation of the supreme value of the individual, no matter how worthless and hopeless that individual may feel."

The Select Committee took all of these opinions into account and concluded that:

"the introduction of a discretionary sentence for murder will enable the judge to take the full circumstances of the crime into account in passing sentence. The Committee make no recommendation for a change in law on this point."

DIANE PRETTY

The litigation regarding the arguments around Diane Pretty, a motor neurone disease sufferer, who sought a review of the DPP decision to refuse to undertake the path of not prosecuting her husband if he assisted her to commit suicide caused much controversy.

In his argument before the European Court, Mrs Pretty's Counsel, Phillip Havers QC observed:

"This is a case about life, about imminent death and about incurable illness...it is also, most of all, a case about an individual, a courageous and determined and dying woman and the extent to which her individual rights are protected under the Convention."

Mrs Pretty was mentally alert and wished to control the time and manner of her dying so as to avoid the suffering and indignity she would otherwise have to endure. Because of her chronic incapacities, she could not commit suicide unaided and wished her husband to help her. She was prepared to do so provided that the DPP gave the undertaking required under the Suicide Act 1961, s 2(4), that he would not prosecute her husband. The DPP refused to do so. Of course, if Mrs Pretty had been physically capable of taking her own life unassisted, she would, as a matter of law, have been able to do so. However, this medium had been denied to her by her disability and the blanket ban under English law which prevented her husband from helping her unless the DPP makes an undertaking pursuant to s 2(4).

The Divisional Court,¹⁵ the House of Lords¹⁶ and the European Court of Human Rights¹⁷ all considered the arguments presented on behalf of Mrs Pretty. Central to those arguments was the consideration of whether Art 3 of the European Convention on Human Rights, which prohibits torture, inhuman and degrading treatment, had been violated. In the Divisional Court, Lord Justice Tuckey observed that Arts 2 (the right to life) and 3 of the Convention protected life and preserved the dignity of life. But he went on to say that they did not protect the right to procure one's own death or confer a right to die. The right to the dignity of life was not a right to die with dignity but the right to live with as much dignity as could be possibly afforded until that life reached its natural end.¹⁸

In the House of Lords, the late Lord Bingham confirmed that Art 3 "which was complimentary to Article 2" enshrined one of the fundamental values of democratic society. He stated that its prohibition of proscribed treatment was absolute, not to be derogated from even in times

of war and national emergency. As Art 2 requires member states to respect and safeguard the lives of individuals within their jurisdiction, so, his Lordship observed: "Article 3 obliged them to respect the physical and human integrity of such individuals." But the House of Lords went on to say that there was nothing in Art 3 which applies to the State which bore on an individual's right to live or to choose not to live. That was not, the House of Lords considered, a part of its application.

The absolute and unqualified prohibition on a member state inflicting proscribed treatment required the word "treatment" not to be given an unrestricted or extravagant meaning. The House of Lords went on to provide the boundaries of the definition of "treatment" to be applied in medical cases. In doing so, their Lordships held that it could not be plausibly suggested that the DPP or any other agent of the UK Government was inflicting the proscribed treatment on Mrs Pretty, whose suffering derived from her cruel disease. They concluded that no legitimate process of interpretation could find that the DPP refusal to give in advance immunity from prosecution to Mr Pretty, if he committed a crime, could fall within the negative prohibition of Art 3.

The House of Lords also concluded that the State was not under a positive obligation to ensure that a competent terminally ill person who wished but was unable to take his or her own life should be entitled to seek the assistance of another without that other being exposed to the risk of prosecution.

In the European Court of Human Rights in the same case, the contention that Mrs Pretty was vulnerable was rejected. A person who was contemplating suicide and was severely disabled should not as a matter of course be regarded as vulnerable, the court opined.

The judgment of the European Court, in essence reproduced all of Lord Bingham's observations from the House of Lords, but the European Court added:

"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 quality of life take on significance. In an area 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 mental decrepitude which conflict with strongly held ideas of self and personal identity."

In ruling that the assisted suicide of Diane Pretty met with the requirements of Art 8(2) of the European Convention on Human Rights, on the basis that the state should be entitled to regulate through the operation of the general criminal law activities which are detrimental to life and safety of other individuals, the European Court differed with the opinion of the majority of the House of Lords which excluded the possibility that a complete ban on assisted suicide might constitute an interference with the applicants right to respect for private life.

Whilst the House of Lords excluded the possibility that the blanket ban on assisted suicide might constitute an interference with an applicants right to a private life, the European Court was of the view that the interference was in harmony with the requirements of Art

8(2) because the state should be entitled through its domestic criminal law regime to control activities which are detrimental to life and safety of other individuals. In short, whilst the House of Lords refused to accept by majority that Diane Pretty's Art 8 rights were capable of violation in the sphere of assisted suicide, the European Court by invoking Art 8(2) disagreed.

Clearly in the light of the ruling in Diane Pretty's case, it is important to draw a distinction between an intention to cause death and an intention simply to relieve pain in the application of medical treatment or substances. A court will not, as a matter of law, order a medical practitioner to treat a patient in a manner contrary to that medical practitioner's clinical judgment and professional duty.

In a Crown Court trial of Dr David Moor the issue of intent became central to the jury's deliberation. In that case, a patient was receiving oral morphine for pain relief. Dr Moor was administering diamorphine in an increased dose, which caused the patient to fall into a deep and peaceful sleep. Later, Dr Moor was seen to inject the unconscious patient with further quantities of diamorphine. Critical to the jury's deliberations was the intention of the doctor in administering such a large dose. The doctor's position at trial was that the patient was suffering such intense pain that could not be relieved by surgery but yet attempted to relieve that pain. To do so he administered the drug in such a dosage that he knew would virtually certainly cause death. The prosecution of Dr Moor proceeded on the basis of Mr Justice Ognall's direction in the case of *Cox*¹⁹ by emphasising the primary intention and distinguishing the secondary affect.

The test was articulated by Mr Justice Ognall in the following terms:

"We all appreciate that some medical treatment, whether of a positive, therapeutic character or solely of an analgesic kind - by which I mean designed solely to alleviate pain and suffering - some treatment carries with it a serious risk to the health or even life, the life of a patient. Doctors are frequently confronted with, no doubt distressing dilemmas. They have to make up their minds as to whether the risk even to the life of their patient, attendant upon their contemplated form of treatment, is such that the risk is, or is not, medically justified. If a doctor genuinely believes, that a certain course is beneficial to his patient, either therapeutically or analgesically, then even though he recognises that that course carries with it a risk to life, he is fully entitled, none the less to pursue it. If in those circumstances the patient dies, nobody could possibly suggest that in that situation the doctor was guilty of murder or attempted murder...but the problem is obviously particularly acute in the case of those who are terminal ill and in considerable pain, if not agony...it was plainly Dr Cox's duty to do all that was medically possible to alleviate...pain and suffering, even if the course adopted carried with it an obvious risk that, as a side effect of that treatment, her death would be rendered lightly or even certain...there can be no doubt that the use of drugs to reduce pain and suffering will often be fully justified notwithstanding that it will, in fact, hasten the moment of death. What can never be lawful is the use of drugs with the primary purpose of hastening the moment of death."

In a paper by Anthony Arlidge QC,²⁰ the case of *R v Adams* is referred to. In that case, which is unreported and was heard at the Central Criminal Court in 1957, Mr Justice Devlin summed up in the following terms:

“Murder is an act or series of acts done by the prisoner which was intended to kill and did in fact kill the dead woman. It does not matter for this purpose that her death was inevitable and her days were numbered. If her death was cut short by weeks or months; it is just as much murder as if it were cut short by years.”

Further cases have made it very clear that there is no special defence available to the medical profession. For instance, in *R v Arthur*²¹ Mr Justice Farquharson observed in his directions to the jury that:

“there is no special law in this country that places doctors in a separate category and gives them extra protection over the rest of us.”

But the law is not inflexible. In *Airedale National Health Service Trust v Bland*²² the House of Lords agreed that it was proper to remove life support from a patient who was in a persistent vegetative state and had been so for three years. In order to maintain him, the patient was fed and hydrated mechanically. When that assistance was removed death was inevitable. The House of Lords characterised the removal of the equipment not as a positive act, but as an omission to sustain life. They observed that whilst it was not lawful for a doctor to kill by a positive act, he or she could decide not to treat a patient who would die as a result. In short, their Lordships were making a distinction between omission and commission.

These latter statements of law provide some succour to the medical profession who will be concerned about falling foul of criminal or civil obligations.

It has been considered whether a defence of necessity, available within the general criminal law could be utilised in cases of euthanasia in a medical context. It has been argued that a medical practitioner could face, in accordance with their professional duty, a situation akin to the defence of necessity. In her article “Euthanasia and the Defence of Necessity: Advocating a More Appropriate Legal Response”,²³ Suzanne Ost asserted that given the potential availability of a defence of diminished responsibility to a relative or spouse who carries out a mercy killing, not allowing the physician to utilise the defence of necessity may place him at greater risk of conviction for murder than the lay person.

Ms Ost confronts the problem raised earlier within this paper of establishing the primary and secondary intentions of a medical practitioner when applying treatment. This is otherwise known as the doctrine of double effect.

The suggestion is that the complex issues of euthanasia should evoke the defence of necessity. This is not new. Over 50 years ago the eminent jurist Glanville Williams suggested that the criminal law should deal with euthanasia through the defence of necessity.²⁴ In his book, published in 1958, Williams referred to a situation where the patient's pain could no longer be alleviated by anything other than a lethal dosage of drugs and stated that:

“the excuse rests upon the doctrine of necessity, there being at this juncture no way of relieving pain without ending life.”²⁵

In her article, Ost eloquently argues that the present position of the law concerning primary

or secondary intent of a medical practitioner when applying a medication or treatment does not effectively reveal the true intent of a physician's behaviour. Furthermore, as she points out, a physician who openly acknowledges a primary intent to cause death or who administers drugs with no pain alleviating effect is left facing a conviction for murder.

Her argument that there should be available to physicians or medical practitioners a defence of necessity, available in other allegations relating to murder, both clarifies the opaque law in relation to primary intent and enhances the defence available to medical practitioners should they be faced with this dilemma.

Ost goes further in her paper to suggest a special defence of mercy killing, favoured in the past by the Criminal Law Revision Committee and referred to earlier in this Paper. Her arguments have some resonance when one compares the imbalance between a defence available to relatives or spouses who commit mercy killings but not to medical practitioners who proceed to carry out an act of euthanasia. But this suggestion is not without its own inherent difficulties and Ms Ost's paper acknowledges that if her suggestion were adopted, a defendant's physician could be completely acquitted whilst the defendant, relative or spouse who successfully relies upon the defence of diminished responsibility (mercy killing) could only find his murder conviction reduced to one of manslaughter.

I have taken some care to lay out the present law in some detail because when a consideration of the DPP's guidelines on assisted suicide is undertaken it is important to emphasise that nothing within these guidelines changes the law in relation to this problematic area of jurisprudence. Whatever considerations are contained within this paper henceforth, they are to be viewed in the context of the law as stated above. Most importantly, assisted suicide is and remains a criminal act.

HOW THE GUIDELINES CAME ABOUT

The DPP's published guidelines on assisted suicide were in response to a ruling by the House of Lords that he had to produce guidelines indicating issues and circumstances to which he would have regard in deciding whether or not to prosecute in cases where there was evidence of criminal behaviour by way of assisting suicide. The DPP, Kier Starmer QC, was at pains to point out in introducing his guidelines that they did not change the law on this issue. He again reminded those who read the guidelines that assisting suicide remained a crime and that only Parliament could change the substantive law. He equally made it clear that the guidelines should not be construed as offering freedom from prosecution to anyone contemplating giving assistance with suicide.

The House of Lords required the DPP to publish guidelines as a result of the case of Debbie Purdy who appealed to that Court requiring such publication. Before the House of Lords' judgment, a significant number of people had argued that no guidelines were necessary, the Suicide Act 1961 and consequent legal authority provided a very clear analysis of the law and that it was misguided to take any action which might be perceived as turning the Crown Prosecution Service into, as Lord Brennan put it, "a consultancy for intending law breakers."²⁶ Indeed, that view was echoed by the court below, in the Court of Appeal, who in terms stated that should Miss Purdy wish her husband to assist her suicide, she had to take legal advice and not expect the DPP to be her legal advisor.

Nevertheless as a result of the House of Lords' judgment, guidelines were issued which contained a number of hypothetical circumstances that would incline the DPP to prosecute an assister of suicide (described as the "suspect") and another list of hypothetical circumstances where he might be inclined to take a more lenient view.

For the purposes of this paper it is right that I should take time to list these categories exhaustively:

A prosecution is more likely to be required if:

- The victim was under 18 years of age.
- The victim did not have the capacity (as defined by the Mental Capacity Act 2005) to reach an informed decision to commit suicide.
- The victim had not reached a voluntary, clear, settled and informed decision to commit suicide.
- The victim had not clearly and unequivocally communicated his or her decision to commit suicide to the suspect.
- The victim did not seek the encouragement or assistance of the suspect personally or on his or her own initiative.
- 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.
- The suspect pressured the victim to commit suicide.
- The suspect did not take reasonable steps to ensure that any other person had not pressured the victim to commit suicide.
- The suspect had a history of violence or abuse against the victim.
- The victim was physically able to undertake the act that constituted the assistance of him or herself.
- 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.
- The suspect gave encouragement or assistance to more than one victim who were not known to each other.
- The suspect was paid by the victim or those close to the victim for his or her encouragement or assistance.
- The suspect was acting in his or her capacity as a medical doctor, nurse, other health care 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.
- 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.
- The suspect was acting in his or her capacity as a person involved in a management or as an employee (whether for payment or not) of an organisational group, a purpose of which is to provide a physical environment (whether for payment or not) in which to allow another to commit suicide.²⁷

The DPP considers that a prosecution will be less likely to be required under the following hypothetical circumstances.²⁸

- The victim had reached a voluntary, clear, settled and informed decision to commit suicide.
- The suspect was wholly motivated by compassion.
- The actions of the suspect, although sufficient to come within the definition of the offence, were of only minor encouragement or assistance.
- The suspect had sought to dissuade the victim from taking the course of action which resulted in his or her suicide.
- The actions of the suspect may be characterised as reluctant encouragement or assistance in the face of a determined wish in the part of the victim to commit suicide.
- 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 at his or her part to providing encouragement or assistance.

These guidelines came into effect on the 25 February 2010 and superseded the Interim Policy issued on the 23 September 2009.

The guidelines emphasise the approach that the CPS take as to whether there is to be a prosecution of any offence. They are not exhaustive. This approach is common to any potential crime and is not specifically there to assist with matters relating to assisting suicide. First, the CPS will consider whether there is a reasonable prospect of success in any prosecution, usually assessed at 50-50. Secondly, and in addition to these criteria, the Crown will consider whether it is in the public interest for a prosecution to take place. The guidelines will assist in determining whether there is such a public interest imperative in a prosecution concerning any allegation of assisted suicide. Only if these criteria are met will there be any recourse to the courts.

In considering whether there is a reasonable prospect of success, the CPS will determine upon the evidence that they have before them whether the suspect did or might have done an act capable of encouraging or assisting the suicide or attempted suicide of another person and whether it can be established or might be possible to establish that the suspect's act was intended to encourage or assist suicide or an attempt at suicide. It is no longer possible to bring a charge under the Criminal Attempts Act 1981 in respect of a s 2 of the Suicide Act 1961 offence by virtue of para 58 of Sch 21 of the Coroners and Justice Act 2009. Attempts to encourage or assist suicide are now captured by the language of s 2 of the 1961 Act as amended.

By virtue of s 59(4) of the Coroners and Justice Act 2009, s 2A is added to the Suicide Act 1961 providing that a person who arranges for someone else to do an act capable of encouraging or assisting the suicide or attempted suicide of another person will also be liable alongside that second person for the encouragement or assistance. The DPP makes it clear in the guidelines that s 2A also emphasises that any person may encourage or assist another person even where it is impossible for the actual act undertaken by the suspect to provide encouragement or assistance - for example, where the suspect believes he or she is supplying the victim with a lethal drug which proves to be harmless.²⁹ The guidelines also within para 24 state that s 2A makes it clear that a person who threatens or puts pressure on the victim comes within the scope of the offence under the new s 2. The rationale of the amendments to s 2 of the 1961

Act are designed to bring the language of this section up-to-date and to make it clear that s 2 applies to an act undertaken via a website in exactly the same way as it does to any other act.

In many respects the guidelines are a useful document in so far as they explain the law and the criminality of actions which maybe perceived to assist suicide. However, what is important to emphasise is that even if there is a reasonable prospect of success on the evidence considered in application to the law, the DPP makes it abundantly clear that the second public interest test applied to establish whether a prosecution can take place may well determine that the matter is not brought before the criminal courts.

In some respects the continuing adherence by the DPP to the public interest test means that the guidelines may not have the draconian and restricting effect upon the DPP's discretion as might have been anticipated. Nevertheless, the closer that any authority is tied down to strict interpretations of response, such as the guidelines encourage, the less the opportunity for merciful discretion to be exercised. The House of Lords in Purdy required the guidelines to assist with a greater element of certainty - but with certainty comes a cost, and that cost is the lack of flexibility.

The DPP's prosecutions key guideline approach to the issue of assisted suicide was described as: "combining a strict interpretation of the Suicide Act for the evidential test (reasonable prospect of success) with the liberal interpretation of public interest."³⁰

It is important to understand the reasons for the House of Lords directing that these guidelines be issued and they can be divined in particular by a reference to the judgment of Lord Hope of Craighead beginning at para 27 of the House of Lords' judgment.³¹ He states that in many respects on one view the law could not be clearer. As he puts it: "it is an offence to assist someone to travel to Switzerland or anywhere else where assisted suicide is lawful." Previous to this the House of Lords again made it clear that nothing in the judgment changed the law - assisted suicide remains illegal. Nevertheless in the same para Lord Hope observes:

"the practice that will be followed in cases where compassionate assistance of the kind that Ms Purdy seeks from her husband is far less certain. The judges had a role to play where clarity and consistency is lacking in an area of such sensitivity."

The information being sought by Ms Purdy would allow her to make a decision that affected her private life, and as such Art 8 was evoked in her successful argument before the House of Lords. Ultimately the House of Lords were of the view that the guidelines should be published to provide consistency with the law. In the opinion of Lord Hope³² the guidelines are to be regarded for the purposes of Art 8(2) of the European Convention on Human Rights, as forming part of the law in accordance with which an interference with the right to respect for private life maybe held to be justified. Lord Hope went on at para 54 to regard the code as:

"a valuable safeguard for the vulnerable, as it enables the prosecutor to take into account the whole background of the case. In most cases its application will ensure predictability and consistency of decision taking, and people will know where they stand."

Some of the guidelines as to whether there should be a prosecution or not are what one might expect to see. They are no different in principle to guidelines given in the courts and by previous codes of conduct in relation to other criminal matters. As seen above the guidelines state that a prosecution is more likely where there is evidence that the suspect has put pressure on the victim to commit suicide or has had a history of violence or abuse towards the victim; or has been paid for the assistance by the deceased (or by persons close to the deceased); or was operating as part of an organisation seeking to facilitate suicide; or where the deceased did not have the mental capacity to reach an informed decision to commit suicide; or have not reached a clear and settled wish to end his or her life; or had not sought assistance to commit suicide. Conversely, the list of mitigating factors includes as we have stated circumstances such as evidence that the assistance was “wholly motivated by compassion” or amounted to only “minor encouragement or assistance” or followed attempts to dissuade the deceased from suicide or was given reluctantly in the face of a determined wish on the part of the deceased to commit suicide.

ASSISTED SUICIDE AND HEALTHCARE

One of the factors in the DPP’s list of circumstances tending in favour of prosecution is where:

“The suspect was acting in his or her 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.”

This factor was added to the list between the draft and the final stages and may well reflect advice contained in a submission to the DPP from the Royal College of Physicians in the course of a public consultation which resulted in over 5,000 responses, by far the biggest response received for any CPS consultation. The College wrote that:

“We believe that our duty of care is to work with patients to mitigate and overcome their clinical difficulties and suffering. It is clear to us that this does not include being, in anyway, part of their suicide. We would go so far as to say that any clinician who has been part, in anyway, of assisting a suicide death should be subject to prosecution. The trust afforded to doctors and nurses in particular gives their views considerable weight with their patients and the public. Clinicians duties of care entail active pursuit of alternative solutions to assisted suicide, not its facilitation. Otherwise they are open to misrepresentation or cynical manipulation.”

The inclusion of medical involvement as an aggravated factor in assisted suicide is controversial. In essence, the argument is that doctors have the expertise and access to drugs to end life. Ruling out their involvement in assisted suicide amounts, it is argued to encouraging “amateur” assistance. The “botched” suicides by amateurs is clearly a serious issue. As a result of these guidelines and the expressed aggravating feature relating to the medical profession and their involvement in the practice of assisted suicide the incidents of “botched” or “amateur” suicide assistance may be more prevalent.

An example of such an event involved the case of Michael Bateman who according to CPS documentation put a bag over his wife’s head containing helium gas. As a result of this her suicide was completed. The CPS was of the view that this was a compassionate act and that

it was not in the public interest to prosecute. As the guidelines make medical intervention in this sphere an aggravating feature, there is considerable concern that this will result in more suffering rather than less to potential victims.

Moreover, it is not only doctors who forwarded the ambit of the DPP's guidelines but others in authority or a position of trust. Nor is it true to say that the guidelines rule out the involvement in assisted suicide of persons with expertise in say, pharmacology. The guidelines indicate that the offence of assisting a suicide will be regarded as aggravated if committed by "a medical doctor, nurse (or) other healthcare professional... and the victim was in his or her care." This would appear to exempt a physician (or nurse, or pharmacist) who prescribed lethal drugs for purposes of assisting a suicide if the recipient was not a patient under his or her care - for example, if such drugs were prescribed under contract to a government agency with responsibility for overseeing the implementation of a law permitting assisted suicide in specified circumstances. What the DPP's guidelines seem to be saying is that physician-assisted suicide, if performed as an act by a doctor towards a patient for whose healthcare he or she is responsible, constitutes an aggravation of the offence, because it could amount to a betrayal of the trust implicit in the doctor-patient relationship.

To counter this problem, the guidelines attempt, as far as possible, to be universal in their application and not limited to specific groups of people.

Another aggravating circumstance which will incline the DPP to prosecute is a situation where "the suspect gave assistance to more than one victim" - which seems to rule out multiple lethal prescriptions but would presumably enable each doctor to write just one. Additionally the DPP considered it an aggravating feature where "the suspect was paid to care for the victim in care or nursing home environment" which appears to discourage the giving of assistance with suicide in such establishments but not, perhaps, by physicians in hospitals or in the home.

ASSISTED SUICIDE AND THE SICK OR DISABLED

Another significant change that occurred in the DPP's Prosecution Policy between its draft and final stages concerns the question of whether assistance given to certain groups of people - more specifically, those who are terminally or chronically ill or severely incapacitated - might be regarded more leniently by the prosecuting authorities than assistance given to others. The draft guidelines stated that a mitigating factor in considering whether a prosecution should be set in hand would be if the deceased had "had a terminal illness, or a severe and incurable physical disability, or a severe degenerative physical condition".

This factor came in for considerable criticism during the public consultation process. While it may appear at first glance that giving assistance with suicide to someone who is seriously ill or incapacitated might constitute an act of compassion, what this element of the draft guidelines was, in effect, saying is that terminally ill or disabled people could expect a lower standard of protection from the law than others who are less seriously ill or incapacitated. Underlying the draft guidelines here was an assumption that assistance with suicide given to sick or disabled people was more understandable - and therefore more acceptable - than assistance given to others. Unsurprisingly, the notion did not commend itself to large numbers of disabled people, and the DPP is to be commended for removing from its final prosecution

guidelines any suggestion that the state of health of the deceased should be a factor in deciding whether a suspect should be prosecuted.

This important change has, however, been criticised, by both supporters and opponents of assisted suicide, on the grounds that it opens the door to more widespread assistance than would have been the case if, as in the draft guidelines, mitigation had focused solely on cases of what might be called “mercy killing”.

The law must protect citizens regardless of their state of health, just as it is blind to gender, age or social status.

But the problem here is the interface between the law ignoring the illness or incapacitation of the victim with one of the principle of the six mitigation factors in the guidelines, that of compassion. The guidelines state that a prosecution will be unlikely where the suspect was “wholly motivated by compassion”.

The exercise of compassion can, as a matter of commonsense, be engendered by sympathy for any debilitating illness or incapacity being suffered by the victim. In such circumstances, whether the guidelines state it or not, a victim who is suffering such illness and incapacity as opposed to one who is not may be the subject of considerable compassion. In short, what was taken out in the interim document is plainly still available under the compassion head of the final mitigation draft.

ASSISTED SUICIDE AND COMPASSION

Perhaps the most important of the six mitigating factors is that the suspect “was wholly motivated by compassion”.

The argument here appears to be that the motivation of someone who assists a suicide can be difficult to establish and that, in the absence of hard evidence to the contrary, a claim by the person under investigation that the assistance he or she has given was motivated by compassion will be accepted and that in consequence, malicious or manipulative assistance is likely to go unpunished. The problem is that compassion and motivation involves a subjective judgment - such a judgment rests on more than simple assurances offered after the event by the suspect. A decision by the DPP on whether or not a prosecution for assisted suicide is appropriate rests on a police investigation of all the circumstances involved in the act, including the known state of mind of the deceased and whether or not any pressure was brought to bear on the deceased to end his or her life. A conclusion that the suspect was “wholly motivated by compassion” cannot be seen in isolation. It has to show consistency with the other evidence surrounding the case. For example, a suspect may perhaps claim, quite truthfully, that he or she acted out of compassion in assisting the suicide but the evidence may show that the deceased, while possibly being in such a state as to arouse compassion, has not (in the words of the guidelines) “clearly and unequivocally communicated his or her decision to commit suicide” or “did not have the capacity (as defined by the Mental Capacity Act 2005) to reach an informed decision to commit suicide”. The “compassion” factor should not therefore be seen in isolation from the other factors. As the guidelines clearly state: “prosecutors must decide the importance of each public interest factor in the circumstances of each case and go on to take an overall assessment”.

CONCLUSIONS

It is important to stress that although the DPP has issued guidelines to ensure that there can be greater understanding as to when he may prosecute, they do not change the law.

Rather, the guidelines make more specific the circumstances under which individuals may, in rare circumstances, be brought before the court. In fact, as is often the case when criteria are reduced and defined into writing, the main casualty will be discretion and particularly here, the DPP's discretion not to prosecute. Where in the past the DPP has been able to exercise mercy, now that the prosecution parameters have been laid down, it will more difficult for the DPP to be flexible.

In any event, there is unlikely to be a significant change in prosecutorial policy relating to assisted suicide. The DPP has always been reluctant to prosecute and it will continue to be so. In this respect, the guidelines have produced little alteration to the position prior to the guidelines.

Perhaps then they should be judged by the reasons laid down in the House of Lords in Purdy, which indicated that the guidelines were designed to give more certainty.

This is an interesting objective. The paucity of cases prosecuted on the basis of an allegation of assisted suicide prior to the guidelines is a graphic indication of how unlikely it would be for there to be any prosecution. In this respect, even before the guidelines, the statistics spoke for themselves.

What the House of Lords required from the guidelines was "accessibility" in so far as the state of the law was concerned. They held that the pre-guideline offence-specific approach fell foul of the requirements that the law should be sufficiently accessible to affected parties or sufficiently precise to enable them to understand its scope and foresee the consequences of their actions and regulate their conduct without breaking the law.

In this respect flexibility has been sacrificed for certainty. This could result in a disadvantage to those who propound that there should never have been prosecution in assisted suicide cases. It may take time, as normal service resumes and there are no prosecutions, but there will come a time when all guideline boxes are ticked which will indicate a prosecution and put the DPP under unwelcome but irresistible pressure to prosecute a case which hitherto, in his discretion, he may have not proceeded with.

A more immediate impact of these guidelines relates to the distinct area of professional medical involvement as an aggravating feature, tending towards prosecution rather than against it.

Without doubt, the unintended consequences of this will make the medical profession far more wary of administering assistance which could be interpreted as assisting suicide. If in doubt, common sense suggests that they will not risk their practising certificates and ultimately their careers by entering into the grey area of reducing pain and suffering which might hasten death. This can, in specific circumstances, lead to the possibility of patients suffering as a result of the withholding of medication treatment which might ultimately cause or contribute to death.

Already the nursing and medical professions are expressing concern as to the invidious position in which they are placed by the guidelines and their professional organisations are considering written directives from patients in the eventuality that medical treatment or pain relief becomes necessary. This development of advance directive, which is presently used to allow patients to direct non-resuscitation in certain circumstances, is a consequence of the medical and nursing professions seeming vulnerable as a result of *Purdy* and the guidelines.

As is often the case in this area, such directives may present their difficulty for the articulate, confident and well supported patient. The vulnerable, threatened, weak and frightened patient is in an entirely different position and is again exposed to the *Purdy* decision in the House of Lords.

There is considerable confusion around the “compassionate assistance” component of the guidelines and the tightening of these criteria will produce both confusion and uncertainty for both families and medical practitioners.

Interestingly the DPP’s guidelines are criticised on both sides of the assisted dying argument. In the recent Commission, set-up to consider the issues around assisted dying and funded by those who wish to legalise the practise, Lord Falconer, a long time supporter of legalising assisted suicide, reported that a person suffering from a terminal illness who is likely to die within 12 months, who is of sound mind and has a settled intention to die, should have the choice of an assisted death. The report observes that the existing law is failing to protect families of those who suffer serious illness as well as the patients themselves and proposes that two independent doctors would be required to ratify patients who met the criteria for assisted death and ensure that other options for end of life care had been explained to them.

The terminology in this report, which as I have emphasised was funded by the pro-assisted suicide lobby and chaired by a supporter of that argument, is also open to criticism. Reference is made to patients not being “unduly” influenced by other people in coming to their decision to die. This raises the question of what is the threshold which qualifies as “undue” influence? Furthermore, the report emphasises that patients with significant and mental health difficulties will be unable to give permission. Again the question arises as to what is “significant”?

It is apparent that both the pro-assisted suicide lobby and those against changing the law have significant criticisms of the DPP’s guidelines. What is becoming more and more obvious is that for those who wish to change the law in relation to assisted death, the guidelines were simply a stepping stone to achieving that objective. For those who felt that the law should not be changed the guidelines did nothing more than strait-jacket the DPP in the exercise of his discretion not to prosecute and in significant respects provide for a number of situations where a vulnerable patient might be significantly disadvantaged.

Perhaps it can best be said of the DPP’s guidelines that they please no one and for many they were unwanted, not least of all by the DPP.

It is important that the DPP’s guidelines are seen in the context of the general law as developed over many years of legal jurisprudence. The guidelines do not change the law. In fact the contrary is the case; the law should be used to interpret the guidelines.

Arguments in legal circles will no doubt continue as to the merit of the House of Lords' decision in *Purdy* in effectively, going against all other legal precedent, including that previously, in *Pretty*. But the practical reality is that the House of Lords, in their last ever judgment before they became the Supreme Court, forced the DPP's hand in producing these guidelines. In many respects the guidelines go much further than the House of Lords postulated (particularly in the judgment of Lord Hope) and the discretionary process of the DPP in matters relating to assisted suicide has been given a significant dose of clarity by the identification of the specific circumstances which should be borne in mind when that discretion is being exercised.

Time will tell as to how the guidelines survive legal analysis, at the coalface, of the court room. Given that in the past there have been very few prosecutions for assisted suicide and with the element of compassion being a particularly strong factor negating any criminal proceedings it may be some time before the guidelines are rigorously tested.

The document was produced as a result of extensive consultation with the public and interested bodies and organisations. The changes and amendments between the interim document and the final draft reflect the fact that the DPP has listened and accommodated many of the suggestions made in consultation.³³

Those on both sides of this controversial subject have their misgivings about these guidelines. Indeed there are some who felt that the government guidelines were not necessary and could only hamper the discretion of the DPP. That is as it may be. The guidelines are here and they are here to stay, no doubt duly amended and developed from time to time. I have outlined within this paper areas which, I feel, may be problematic. Nevertheless, providing that the aggravating and mitigating factors enunciated by the DPP are interpreted in accordance with the unchanged law as laid down within this Paper, it is my view that the guidelines can work and will enhance and maintain the existing law.

* I am grateful for the invaluable research by Sarah Walker of UCL.

1 See French (1955) 39 Cr App R 192, Per Lord Goddard CJ.

2 For further background on this issue see Williams "The Sanctity of Life", Ch 7; St. John Stevas, "Life, Death and the Law", Ch 6; and the Second Report of the Criminal Law Revision Committee Cmnd 1187 (1960).

3 [[2002] EWHC 429 (Fam), [2002] 2 All ER 449.

4 (1986) 8 Cr App R (S) 419 CA.

5 (1984) 6 Cr App R (S) 406.

6 (1983) 5 Cr App R (S) 342.

7 See *R v McShane* (1977) 66 Cr App R 97.

8 See *National Coal Board v Gamble* [1959] 1 QB 11 at 24 Per Devlin J.

9 See *R v Clarkson* [1971] 3 All ER 344, [1971] 1 WLR 1402

10 See *R v Bainbridge* [1960] 1 QB 129, [1959] 3 All ER 200.

11 See *Thambiah v The Queen* [1966] AC 37, [1965] 3 All ER 661; *Tuck v Robson* [1970] 1 All ER 1171, [1970] 1 WLR 741.

12 (2002) 35 EHRR 1.

13 [1984] 1 QB 795.

14 The booklet proved very popular. In less than 18 months after its publication, 8,300 copies had allegedly been sold.

15 [2001] EWHC Admin 788, [2001] All ER (D) 251 (Oct)

16 [2001] UKHL 61, [2002] 1 AC 800, [2002] 1 All ER 1.

17 (2002) 35 EHRR 1.

18 Although it should be noted that that right might mean not taking futile or undignified steps to prolong life beyond its natural end. See *Re J (A Minor) (Child in Care: Medical Treatment)* [1993] Fam 15.

19 See [2000] Crim LR 37.

20 See "The Trial of David Moor" by Anthony Arlidge QC, [2000] Criminal Law Review 31 at p 33.

21 12 BLNR 1.

22 [1993] AC 789, [1993] 1 All ER 821.

23 [2005] Criminal Law Review 355.

24 See Glanville Williams, *The Sanctity of Life and the Criminal Law* (Faber, London 1958) at p 286-288.

25 See p 288.

26 Criminal Bar Quarterly, December 2009 p 11.

27 See para 44 of the guidelines.

28 See para 45 of the guidelines.

29 See para 23 of the Guidelines.

30 Mullock A, "Prosecutors making (bad) law?", *Medical Law Review* 2009 17: 209-99

31 *R (on the application of Purdy) v Director of Public Prosecutions* [2009] UKHL 45, [2010] 1 AC 345, [2009] 4 All ER 1147.

32 At para 47.

33 Although there were some issues in which the Director of Public Prosecutions went against the trend of consultation. In particular, the majority view in the consultation was that taking into account the views of a victim of crime, in the context of assisted suicide, those who had a clear settled and informed intent to commit suicide, the process was going against the norm of criminal procedure in that the view of a victim is irrelevant as far as the commission of the offence is concerned, but may be relevant for the purposes of sentencing.