Response to the CPS Consultation on the Interim Policy for Prosecutors in respect of Cases of Assisted Suicide

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1. Terminology

1.1. The use of the word ‘victim’ to describe someone who has made an informed decision to end his or her own life is inappropriate. The ‘context of the criminal law’ does not provide sufficient justification for the use of this term. Using consistent terminology across all similar CPS policies is undoubtedly desirable, but in this case its desirability is outweighed by the political weight of the term. In the debate over assisted dying, the word ‘victim’ is often used politically by opponents of legalisation.¹ By using it, the policy unintentionally aligns itself with this political agenda. A neutral term like ‘person assisted’ should be used which does not have connotations for either the anti-legalisation or pro-legalisation campaigns.

1.2. A ‘wish to commit suicide’ is insufficiently indicative of decisive action. Factors 2, 3 and 4 in favour of prosecution and Factors 1 and 2 against prosecution should refer to ‘a decision to commit suicide’ and ‘a request for assistance in suicide’. The former formulation would also be consistent with the terminology used in Factor 2 in favour of prosecution (‘informed decision’), which itself is inconsistent with the terminology used in Factor 1 against prosecution (‘informed wish’).

2. Scope of the consultation document

2.1. The consultation document simply lists public interest factors for and against prosecution. No attempt has been made to explain the reasons why these factors have been chosen and/or why other factors have not been chosen. In order to be clear about ‘what is being proposed’ (HM Government, Code of Practice on Consultation, 2008, [3]), some indication of the reasons for the proposals should have been provided. While some of the factors might be regarded as fairly self-explanatory, others are not. Examples of those which require further explanation and/or reasons for their inclusion are given below in [6.1], [7.1], [8.1] and [12.1].

2.2. In addition, no explanation is provided for the decisions made about duplication, discussed below at [4].

2.3. Neither is an explanation provided for the decision to allocate greater weight to certain factors, discussed below at [16].

2.4. There is no explanation provided for the decision taken by the DPP (in [5] of the Interim Policy) to include all offences which could be prosecuted under s.2(1) (which could include

providing medication, writing a prescription, or other technical or practical assistance with the act of suicide itself), rather than covering only those providing assistance with travel to a country where assisted suicide is lawful, as Lord Hope envisaged (Purdy [54]), and as would be consistent with the facts of the Purdy case.

2.5. While the DPP’s broad interpretation could be inferred from the speeches of Baroness Hale at [63]-[69], Lord Brown at [82]-[87] and Lord Neuberger at [100]-[106], reasons for the decision to depart from the leading speech of Lord Hope and to issue guidelines which will have significantly greater impact than mandated by the decision of the House of Lords would have been both helpful in interpreting the policy, and interesting.

3. Scope of the consultation

3.1. The consultation limits most of the consultees’ answers to yes/no, which makes them so superficial as to be almost meaningless. Take, for example, Factor 2 in favour of prosecution: “The victim’s capacity to reach an informed decision was adversely affected by a recognised mental illness or learning difficulty.” If the person assisted did not have capacity to make an informed decision, this is clearly a relevant factor in favour of prosecution. But the factor itself is poorly drafted and fails to recognise key distinctions within the law governing mental capacity. Particularly in the context of a terminal illness, capacity might be affected by that that physical illness, its treatment or palliation. Or it could be affected by a mental disorder which is not a mental illness.2 A more appropriate formulation of this factor would be: ‘The person assisted did not have capacity to reach an informed decision.’

3.2. None of the questions in the consultation allow for this type of analysis of a factor (with the exception of the catch-all Q9). Consultees are simply invited to accept, reject and add factors, and then accept, reject and add factors to the ‘more weight’ sub-lists. By providing no opportunity for a response to each individual factor beyond acceptance or rejection, the structure of the consultation questions is unduly restrictive, likely to frustrate consultees, impoverish their answers and limit the impact of the consultation (HM Government, Code of Practice on Consultation, 2008,[3]) so that it becomes an exercise in quantitative data collection rather than a real opportunity to improve the quality of the policy.

4. Duplication across the lists

4.1. While the principle embodied in [16] of the Interim Policy is clear, the actual implementation of it is less so.

4.2. Why are Factors 3-7 and 9-10 in favour of prosecution replicated in the list of factors against prosecution, but Factor 2 in favour of prosecution is not? See [15.1] below.

4.3. Why is the converse of Factor 7 against prosecution not found in the list of factors in favour of prosecution? See [9.2] below.

4.4. Analogously, the converse of Factor 10 against prosecution seems a relevant factor in favour of prosecution. See [9.3] and [13] below.

5. The decision to commit suicide: Factors 2, 3 and 4 in favour of prosecution

2 Some examples of possible causes for an impairment of capacity are found in [4.12] of the Mental Capacity Act 2005 Code of Practice (2007).
5.1. At a minimum, the decision to commit suicide should meet the requirements for a valid consent to or refusal of medical treatment, that is, the decision should be made by a person with capacity, it should be adequately informed, and voluntary.

5.2. On capacity, see [3.1] above.

5.3. On terminology, see [1.2] above. In Factor 3 in favour of prosecution, it would be preferable to replace ‘did not have a clear, settled and informed wish to commit suicide’ with ‘had not made a clear, well-considered and informed decision to commit suicide which he or she clearly communicated to the suspect’. Factor 4 in favour of prosecution could then be omitted.

5.3.1. Alternatively, Factor 3 could read: ‘The person assisted had not made a clear, well-considered and informed decision to commit suicide’ and Factor 4 could read: ‘The person assisted had not clearly and unequivocally communicated his or her decision to commit suicide to the suspect.’

5.3.2. The decision made by the person assisted should also be voluntary. This is discussed below, [7.1].

5.4. On an informed decision, see [9.1] below.

5.5. Some jurisdictions have a waiting period between the request and the assisted suicide, to ensure that the request is sustained over time and to further ensure voluntariness.3 One way of incorporating such a cooling-off period into a factor-based approach would be to mention within Factor 3 in favour of prosecution the need for a certain amount of time to have elapsed since the request in order for the person assisted’s decision to be considered ‘settled’ or ‘well-considered’.

6. The condition of the person assisted: Factor 6 in favour of prosecution (and Factor 4 against prosecution)

6.1. This is one example of a factor for which reasons would have been extremely helpful, particularly in light of Baroness Hale’s comments in Purdy ([68]). Jurisdictions in which assisted suicide is permitted have taken different views on this criterion. In Oregon, assisted suicide is restricted to those with a terminal illness, which is defined as “an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six (6) months.” (§1.01(12)) In the Netherlands and Belgium, a certain level of suffering is required. In the Netherlands, the “attending physician . . . must have been satisfied that the patient’s suffering was unbearable, and that there was no prospect of improvement”.4 In Belgium, the “patient [must be] in a medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated, resulting from a serious and incurable disorder caused by illness or accident” (s.3§1). Factor 6 takes a clear view against the Oregon ‘terminal illness only’ approach, and also against the Netherlands/Belgium ‘unbearable and hopeless suffering’ approach, perhaps because suffering is presumed in the three situations described. With no explanation of how this factor was arrived at, and why it was chosen over other alternatives, there cannot be clarity about what is being proposed and why.

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3 See, eg, Oregon Death With Dignity Act, §§3.01(6), 3.06, 3.08. In Belgium, If the patient ‘is clearly not expected to die in the near future’, a second consultation with either a psychiatrist or a relevant specialist is required and there is a waiting period of at least one month. Belgium, Act on Euthanasia of May 28 2002, (2003) 10 Eur J Health Law 329, s.3§3.

6.2. ‘No possibility of recovery’ is a difficult standard to meet given the inherent difficulties associated with medical prognosis. What will constitute a ‘recovery’? Will it be a cure, remission, or an improvement in the person assisted’s condition?

7. Influence of the suspect: Factor 8 in favour of prosecution

7.1. The focus here is on the suspect’s actions (or lack thereof) rather than the quality of the decision made by the person assisted. Is one of the aims of this factor to ensure that the person assisted’s decision was voluntary? If so, some reference to the standard of ‘undue influence’ or voluntariness should be made. If this is not one of the aims of this factor, then voluntariness should be included either within this factor or within Factor 3 in favour of prosecution. The latter is preferable as ‘voluntary’ could then also be included in Factor 1 against prosecution.

7.2. Should these possibilities not be alternatives? If so, the ‘and’ in the final clause should be replaced with ‘or’.

8. Preventing professional or organised amateur involvement: Factors 10-14 and 16 in favour of prosecution and Factor 6 against prosecution

8.1. This group of factors seem concerned to ensure that assistance in suicide remains an amateur activity carried out by inexperienced individuals without the assistance of professionals or amateur organisations (as in Switzerland). Unlike all of the other jurisdictions which permit assisted suicide (and in the Netherlands and Belgium, euthanasia as well), where the activity is carried out in whole or in part by physicians, the inclusion of these factors will discourage the involvement of physicians, unless the person assisted is fortunate enough to have someone with medical expertise amongst his or her family or close friends who is willing to provide expert assistance. The reasons for the privileged status of the reluctant amateur over the expert professional are unclear. Why is there a greater public interest in the prosecution of health care professionals than family members, if both are wholly motivated by compassion (Factor 7 in favour of prosecution; Factor 5 against prosecution)? If assisted suicide is thought to be incompatible with the professional role, surely this is a matter for the General Medical Council and the Nursing and Midwifery Council, rather than the DPP?

8.2. The advantages of medical involvement are manifold, and include a lower risk of botched suicides and suffering during the suicide or attempted suicide and the possibility of screening for possibly hitherto unknown mental disorders including depression.

8.3. Whether intentionally or not, these factors may keep the number of assisted suicides which take place entirely within the UK relatively low. There will still be an incentive to travel to a permissive jurisdiction such as Switzerland, when physically and financially possible, where such expertise is available. Those without supportive friends and family may commit suicide

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5 R.S. Magnusson, Angels of Death – Exploring the Euthanasia Underground (Yale Univ. Press, 2002) 202-10. See also, S. Jamison, ‘When Drugs Fail: Assisted Deaths and Not-So-Lethal Drugs’ in M.P. Battin & A.G. Lipman, eds., Drug Use in Assisted Suicide and Euthanasia (Informa Healthcare, 1996) 223-243 at 241: “How does one accomplish an assisted death in the most “efficient” and yet emotionally positive manner unless one has done it before or has well-developed models to use for this purpose? . . . [T]he lack of models, experience, and training makes this an act that must be constantly reinvented. Every experience is new, fraught with its own fears, hesitancy, and ignorance, and nearly every one who participates is an actor with an unrehearsed script.”

6 See Oregon Death With Dignity Act, §3.03: “If in the opinion of the attending physician or the consulting physician a patient may be suffering from a psychiatric or psychological disorder, or depression causing impaired judgment, either physician shall refer the patient for counseling. No medication to end a patient’s life in a humane and dignified manner shall be prescribed until the person performing the counseling determines that the person is not suffering from a psychiatric or psychological disorder, or depression causing impaired judgment.”
earlier than they would have wished, or travel to Switzerland when they are still able to do so on their own.

8.4. By strongly discouraging medical involvement, the guidelines place a heavy burden on supportive friends and family. If travelling to a permissive jurisdiction is not possible, for financial or health reasons, then the burden of assisting the suicide will fall on someone with no experience (Factor 12 in favour of prosecution) and no access to relevant information (Factor 11 in favour of prosecution). “Medical condition, body build, drug history and narcotic tolerance are all variables that must be factored in when developing a specific strategy to achieve death.” Without this knowledge, and without access to appropriate medications, the guidelines are likely to result in assisted suicides which are more difficult, less successful and more stressful for the person assisted and his or her friends and family (including the suspect) than would be the case if medical expertise were permitted in some form.

9. Other possible factors in favour of prosecution

9.1. A separate factor explaining what is meant here by an ‘informed decision’ is needed. For example, “The person assisted was not informed of the information relevant to his or her decision, including information about his or her condition and life expectancy.”

9.2. To be consistent, it should be a factor in favour of prosecution if the suspect has provided direct assistance with the means of suicide (in contrast to ‘minor assistance’ discussed below, [11.2]).

9.3. It should be a factor in favour of prosecution if the person assisted had not fulfilled the requirements of a redrafted converse of Factor 10 against prosecution. See [13] below.

9.4. Unlike the regimes in Oregon, Belgium and the Netherlands, no residency requirements are mentioned. In the absence of a requirement that the person assisted and the suspect both be resident within England and Wales, individuals may travel to this jurisdiction in order to undertake an assisted suicide with significantly less chance of prosecution than there might be in their home jurisdiction, just as individuals travel to to Switzerland for assisted suicides, and to Mexico to obtain veterinary euthanasia medications.

10. Factors 1 and 2 against prosecution

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7 Magnusson, above n.5, 203.
8 In the Oregon Death With Dignity Act §1.01(7) “‘Informed decision’ means a decision by a qualified patient, to request and obtain a prescription to end his or her life in a humane and dignified manner, that is based on an appreciation of the relevant facts and after being fully informed by the attending physician of: (a) his or her medical diagnosis; (b) his or her prognosis; (c) the potential risks associated with taking the medication to be prescribed; (d) the probable result of taking the medication to be prescribed; (e) the feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.” The Dutch statute requires that the doctor “have informed the patient about his situation and his prospects” (s.2(1)(c)). The Belgian statute states that the doctor must “inform the patient about his/her health condition and life expectancy” (s.3§2(1)).
9 Oregon Death With Dignity Act, §§1.01(11), 3.10.
10.1. On the person assisted’s decision, see [1.2], [5.1] and [7.1] above. In Factor 1, one could replace ‘had a clear, settled and informed wish to commit suicide’ with ‘had made a clear, well-considered, informed and voluntary decision to commit suicide which he or she clearly communicated to the suspect’. Factor 2 against prosecution could then be omitted.

10.1.1. Alternatively, Factor 1 could read: ‘The person assisted had made a clear, well-considered, informed and voluntary decision to commit suicide which he or she clearly and unequivocally communicated his or her decision to commit suicide to the suspect.’

10.2. On an informed decision, see [9.1] above.

10.3. On waiting periods, see [5.5] above.

11. Minor assistance: Factor 7 against prosecution

11.1. What is meant by ‘minor assistance’? Is making travel arrangements ‘minor assistance’? If so, then this should be made clear to those contemplating providing such assistance and seeking to use the guidelines to assess the likelihood of prosecution. Examples of minor assistance should be given within this factor.

11.2. Providing medication, writing a prescription, setting up an intravenous drip which is then triggered by the patient, or other technical or practical assistance with the act of suicide itself (including, for example, crushing or dissolving medication) should make prosecution more likely than less proximate assistance, such as making travel arrangements to a permissive jurisdiction or providing medical records for use in a permissive jurisdiction (see BMJ 2009;339:b3275), and this should be made clear to potential suspects.

11.3. To what does the final clause of this factor relate? Is it intended to refer to someone who assists a suicide by dispensing medication which has been prescribed, or by prescribing medication for another purpose which is subsequently used in a suicide? If not, what kind of actions are envisaged?

12. Reluctant assistance: Factors 9 and 12 against prosecution

12.1. These factors seem to encapsulate an idealised scenario that involves an unwilling ‘suspect’ and a determined ‘victim’. Again, no reasons for the inclusion of these factors are provided. What if the assister is fully supportive of the person assisted’s decision, recognising that the person assisted has reached his or her own decision and agreeing that it is the right course of action for him or her in the circumstances? Does this make prosecution more in the public interest than if the suspect is ‘reluctant’ and sought to ‘dissuade’ the person assisted?

Factor 9 envisages the decision to seek assisted suicide as an unwise or irrational decision from which the person should be dissuaded, or at least suggests that this is how the ideal suspect should react to the decision. The inclusion of these two factors seems to prescribe a certain kind of emotional reaction on the part of a family member or friend to the person assisted’s condition, for example, not accepting a terminal diagnosis, or wanting the person to remain alive as long as possible.

13. Engagement with medical care: Factor 10 against prosecution

13.1. What will constitute ‘a reasonable extent’ in relation to this factor? In Belgium, there must be ‘no reasonable alternative’ to the patient’s request for euthanasia (Art. 3§2(1)), which mirrors a similar Dutch requirement (s.2(1)(d)). However, the inclusion in the Belgian Law of an incurability criterion means that a patient’s refusal of potentially curative treatment will
prevent access to euthanasia,\textsuperscript{13} unlike the Netherlands where the position is more nuanced.\textsuperscript{14} In Belgium, the refusal of treatment which may assuage suffering will not have this effect,\textsuperscript{15} and the situation is similar in the Netherlands in the kinds of cases envisaged by the guidelines (described in Factor 6 in favour of prosecution and Factor 4 against prosecution) ie where the source of the suffering is somatic.\textsuperscript{16}

13.2. Two issues must be resolved in order for persons affected by the guidelines to be able to assess the impact of this factor in their case. First, what kind of treatment options must the person assisted pursue? What if the person assisted has turned down a burdensome treatment option with a small chance of successful ‘cure’?

13.3. Second, what kind of palliative care options must the person assisted pursue?\textsuperscript{17} Is a consultation sufficient, or must the person assisted have tried palliative care?

14. Reporting and co-operation: Factor 13 against prosecution

14.1. Reporting of assisted suicides is in the public interest so that they can be properly investigated and recorded, and prosecuted when this is in the public interest. This factor should include ‘The suspect reported the assisted suicide to the police’.

15. Other possible factors against prosecution

15.1. On capacity, see \[4.2\] above. For example, one could include: ‘The person assisted had capacity to reach an informed decision.’

15.2. On an informed decision, see \[9.1\] above. For example, ‘The person assisted was informed of the information relevant to his or her decision, including information about his or her condition and life expectancy.’

16. Weighting

16.1. Although this is not explained within the Interim Policy, the intention appears to be that factors which relate to the person assisted’s decision will carry greater weight (Factors 1-6 and 8 in favour of prosecution; Factors 1-4 against prosecution). This is a coherent policy emphasis.

16.1.1. The additional factors proposed in relation to capacity (\[15.1\]), information (\[9.1\] and \[15.2\]) and voluntariness (\[5.3.2\], \[7.1\] and \[10.1\]) would need to be included in this group.

16.2. In addition, Factor 7 in favour of prosecution and Factor 5 against prosecution relate to the suspect’s motivation and appropriately carry greater weight.

16.3. Similarly, Factor 7 against prosecution, and its converse in favour of prosecution (see \[9.2\]) should both carry greater weight as they relate to the suspect’s actions.


\textsuperscript{14} Griffiths et al., \textit{Euthanasia and Law in Europe}, above n.10, 91-3.


\textsuperscript{16} P. Lewis, \textit{Assisted Dying and Legal Change} (OUP, 2007) 127.

\textsuperscript{17} This factor goes some way to providing a palliative filter. A palliative filter (debated but not included in the Belgian legislation) is a requirement that the patient be provided with advice by a palliative care team prior to consideration of a request for assisted suicide. See Lewis, ‘Euthanasia in Belgium’, above n.15, 134-136.
16.4. However, the designation of Factor 6 against prosecution as carrying greater weight while the converse factor (Factor 10 in favour of prosecution) does not do so is baffling. I have already discussed my reservations about this factor ([8] above), but even if these reservations are disregarded, the imbalance of weight attached to this factor is incoherent. Given the conceptual need to group Factor 10 in favour of prosecution with the other factors discussed in [8] above, it would be appropriate to remove Factor 6 against prosecution from the group of factors carrying greater weight. This would allow for a principled approach to the designation of greater weight, which would cover only those factors which relate to the person assisted’s decision and the suspect’s motivation and actions.