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# PROSECUTORIAL DISCRETION IN ASSISTED DYING IN CANADA: A PROPOSAL FOR CHARGING GUIDELINES

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An Expert Panel of the Royal Society of Canada and a Select Committee of the Québec National Assembly both recently recommended the issuance of permissive guidelines for the exercise of prosecutorial discretion on voluntary euthanasia and assisted suicide and "medical aid in dying" respectively. It seems timely, therefore, to propose a set of offence-specific guidelines for how prosecutorial discretion should be exercised in cases of voluntary euthanasia and assisted suicide in Canadian provinces and territories. We take as our starting point the only existing guidelines of this sort currently in force in the world (i.e. the British Columbia Guidelines, and the England and Wales Guidelines). In light of certain concerns we have with these guidelines, we outline an approach to constructing guidelines for Canadian jurisdictions that begins with identifying three guiding principles we argue are appropriate for this purpose (respect for autonomy, the need for high-quality prosecutorial decision making, and the importance of public confidence in that decision making), and ends with a concrete and detailed set of proposed guidelines. The paper is consistent with, but also extends, the work of the Royal Society of

Un panel d'expert de la Société Royale du Canada et une Commission spéciale de l'Assemblée nationale du Québec ont tous les deux récemment recommandé que soit émises des directives permettant exercice d'un pouvoir de poursuite discrétionnaire concernant l'euthanasie et le suicide assisté et « l'assistance médicale pour mourir », respectivement. Il semble donc à propos de proposer une série de directives spécifiques aux offenses sur la façon dont le pouvoir de poursuite discrétionnaire dans les territoires et provinces canadiennes serait appliqué dans les cas d'euthanasie et de suicide assisté. Nous avons pris comme point de départ les seules directives de la sorte existant déjà (c'est-à-dire celle de la Colombie-Britannique et de l'Angleterre et du Pays de Galles). Par contre, compte tenu de certaines de nos réserves concernant ces directives, nous avons ensuite établi les grandes lignes d'une approche permettant de mettre sur pied des directives pour les juridictions canadiennes, qui débute par l'identification de trois principes de base qui sont selon nous appropriées à cette fin (respect de l'autonomie, besoin pour une grande qualité de prise de prise de décision du poursuivant et la confiance

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Canada Expert Panel on End of Life Decision Making.

du public envers cette prise de décision) pour se terminer par une série de directives concrètes et détaillées. Le présent document est compatible avec le travail de la Société royale du Canada tout en en augmentant la portée.

## Introduction

In Canada, it is illegal to counsel, aid, or abet a person to commit suicide.[1] Voluntary euthanasia is also illegal, as it contravenes the *Criminal Code* prohibition on murder.[2] While clear, the legal status of these forms of assisted death has been the subject of seemingly intractable debate for a number of years. However, during the past year, there have been three major developments in the arena of assisted death law and policy. First, the Royal Society of Canada appointed an Expert Panel on End-of-Life Decision Making tasked with contribution to the public policy debate on end of life law and policy in Canada ("RSC Panel").[3] Second, the Québec National Assembly appointed a Select Committee on the Right to Die with Dignity to study the issues ("Québec Committee").[4] Third, a constitutional challenge of the *Criminal Code* prohibitions on voluntary euthanasia and assisted suicide was launched in British Columbia.[5] Within a seven-month period, the RSC Panel, the Québec Committee, and the BC Supreme Court released their respective reports and decision. All three, each in their own way, concluded that the current laws on assisted suicide and voluntary euthanasia must change. In this paper, we explore one of the recommended avenues of reform arising from the RSC Panel and the Québec Committee: guidelines for the exercise of prosecutorial discretion.[6]

The RSC Panel report included the following recommendation:

> The Panel recommends that, unless or until the *Criminal Code* is reformed as recommended above ["that the prohibitions on assisted suicide and voluntary euthanasia in the Criminal Code be

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[1] *Criminal Code*, RSC 1985, c C-46, s 241(b).

[2] *Ibid*, s 229(a)(i).

[3] The Royal Society of Canada Expert Panel, *End-of-Life Decision Making* (Ottawa: RSC, 2011), online: <http://rsc-src.ca/sites/default/files/pdf/RSCEndofLife Report 2011_EN_Formatted_FINAL.pdf > [RSC Panel Report].

[4] National Assembly of Québec Select Committee, *Dying With Dignity* (Québec City: National Assembly of Québec, 2010) at 37, online: <www.assnat.qc.ca/en/actualites-salle-presse/nouvelle/Actualite-25939.html> [Québec Committee Report].

[5] *Carter v Canada (AG)*, 2012 BCSC 886 (available on CanLII) [*Carter*].

[6] Both the RSC Panel and the Québec Committee made recommendations beyond prosecutorial guidelines (e.g. changes to the *Criminal Code* and changes to provincial legislation respectively). However, these are not the subject of this paper.

> modified such that, in carefully circumscribed and monitored circumstances, they are legally permissible" (at 96)], those with authority over prosecutorial policies in all provinces and territories introduce such policies to provide guidance with respect to the exercise of prosecutorial discretion and to make clear the circumstances within which a prosecution for assisted suicide or voluntary euthanasia would not be in order.[7]

The Québec Committee report included the following recommendation:

> The Committee recommends that the Attorney General of Québec issue directives (in the form of "guidelines and measures") to the Director of Criminal and Penal Prosecutions to ensure that a physician who provides medical aid in dying in accordance with the criteria provided by law cannot be prosecuted.[8]

In light of these recommendations, a challenge has clearly been set: to develop offence-specific guidelines for the exercise of prosecutorial discretion in cases of voluntary euthanasia and assisted suicide.[9]

In this paper we seek to meet this challenge. We propose specific guidelines to supplement the existing general guidelines. First, we outline the way in which charging guidelines operate in Canadian provinces in relation to the prosecution of offences generally. Second, we consider the offence-specific guidelines promulgated in British Columbia ("Crown Counsel Policy Manual: Euthanasia and Assisted Suicide")[10], and England and Wales ("Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide")[11]. We

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[7] RSC Panel Report, *supra* note 4.

[8] Québec, Select Committee on Dying with Dignity, *Report* (Québec City: National Assembly of Québec, 2012) at 90, online: <www.assnat.qc.ca/en/actualites-salle-presse/nouvelle/Actualite-25939.html> [Québec Committee Recommendations].

[9] Both the RSC Panel and the Québec Committee called for prosecutorial charging guidelines and indicated some content for them by way of "criteria" (Québec) or "core elements" (RSC Panel) for a permissive regime. However, neither one developed actual guidelines.

[10] Office of the Attorney General, by the Criminal Justice Branch (Victoria: AG, 2004), online: <www.ag.gov.bc.ca/prosecution-service/policy-man/pdf/EUT1-EuthanasiaAndAssistedSuicide-15Mar2004.pdf> [BC Guidelines].

[11] England and Wales, Director of Public Prosecutions, "Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide" by the Crown Prosecution Service (London: DPP, 2010), online: <www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.pdf> [England and Wales Guidelines]. These guidelines

look first at the BC Guidelines, as they are the only existing assisted death offence-specific guidelines from a Canadian jurisdiction. We then focus on the England and Wales Guidelines, the only existing detailed assisted suicide prosecutorial charging guidelines in the world.[12]

However, while these two sets of guidelines provide a useful starting point, we argue that they are deficient in a number of respects. We therefore advance an approach to constructing alternative guidelines that begins by identifying three guiding principles that we argue are appropriate for this purpose: respect for autonomy; the need for high-quality prosecutorial decision making; and the importance of public confidence in that decision making. Using those principles, we then construct our own detailed guidelines for the exercise of prosecutorial discretion in those cases of voluntary euthanasia and assisted suicide that the RSC Panel concluded should be permitted in Canada.

For ease of reference, as each element is discussed in detail, the relevant portion of our proposed guidelines is set out in a text box. The proposed guidelines are set out in full in Appendix I.[13] Before proceeding, we must

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do not apply in Scotland. See James Chalmers, "Assisted Suicide: Jurisdiction and Discretion" (2010) 14:2 Ed L Rev 295; Sheila AM McLean, Clare Connelly & J Kenyon Mason, "Purdy in Scotland: We Hear, But Should We Listen?" (2009) 4 Jurid Rev 265 at 265.

[12] In drafting our proposed guidelines, we were influenced by the experience of the Netherlands with charging guidelines between 1994 and 2002. However, the Dutch guidelines grew out of the defence of necessity, which has not been accepted by Canadian courts as the foundation for a permissive regime with respect to voluntary euthanasia and assisted suicide. See e.g. *R v Latimer*, 2001 SCC 1, [2001] 1 SCR 3, 193 DLR (4th) 577. Furthermore, the Dutch guidelines were superseded by the Dutch *Termination of Life on Request and Assisted Suicide (Review Procedures) Act* (entered into force April 2002), online: <www.nvve.nl/assets/nvve/english/EuthanasiaLaw.pdf>. Therefore, we will not review them here.

[13] For those who are persuaded by the limits on access to assisted suicide or voluntary euthanasia recommended by Madam Justice Smith in *Carter* or the Québec Committee, we offer elements that could be added to our proposed guidelines to make them consistent with Madam Justice Smith's limits (Appendix II) or the Québec Committee's limits (Appendix III). It must be emphasized that Madam Justice Smith's decision does not contemplate prosecutorial charging guidelines but rather compels changes to the *Criminal Code*. It is not anticipated that the draft guidelines provided in Appendix II would be implemented, should the government fail in its attempts to have her decision overturned at the BC Court of Appeal and

address three preliminary issues. First, we offer the following definitions of our key terms (taken from the RSC Panel Report):

> "Assisted suicide" is the act of intentionally killing oneself with the assistance of another. An example is a woman with advanced ALS [amyotrophic lateral sclerosis, also known as Lou Gehrig's Disease] who gets a prescription from her physician for barbiturates and uses the drugs to kill herself.
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> "Voluntary euthanasia" is an act undertaken by one person to kill another person whose life is no longer worth living to them in accordance with the wishes of that person. An example is a man bedridden with many of the consequences of a massive stroke whose physician, at his request, gives him a lethal injection of barbiturates and muscle relaxants.[14]

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the Supreme Court of Canada. In such a case, the *Criminal Code* would be revised to reflect the framework set out in her decision. Similarly, the Québec Committee did not recommend prosecutorial charging guidelines alone but, rather, in addition to changes to provincial legislation. It is not anticipated that the draft guidelines provided in Appendix III would be implemented as is, should the Québec National Assembly pass legislation with respect to medical aid in dying. If it did, there would be provincial legislation to set out a statutory framework within which prosecutors would be required to act. The charging guidelines would be drafted against that statutory backdrop. Rather, these additional draft guidelines are offered to show what our proposed prosecutorial charging guidelines would look like if the concerns regarding protection of the vulnerable, expressed in Madam Justice Smith's decision and in the Québec Committee Report, but rejected by the RSC Panel, were reflected in them, through additional factors tending to favour prosecution. If the government is successful on appeal against Madam Smith's decision, then a provincial or territorial Attorney General wishing to provide guidance re: prosecutions of assisted suicide and voluntary euthanasia and persuaded by her proposed limits on access, could use the draft guidelines presented in Appendix II. If there is no legislation passed in Québec but the Attorney General nonetheless wishes to follow the recommendations of the Québec Committee with respect to charging guidelines, then he or she could use the draft guidelines presented in Appendix III.

[14] These definitions were taken from the definitions provided in the RSC Panel Report, *supra* note 4 at 7. In turn, the Panel's definitions were drawn (and sometimes modified) from Jocelyn Downie, *Dying Justice: A Case for Decriminalizing Euthanasia and Assisted Suicide in Canada* (Toronto: University of Toronto Press, 2004) at 6-7; Canada, Special Senate Committee on Euthanasia and Assisted Suicide, *Of Life and Death: Final Report* (Ottawa: Special Senate

Second, we explain our use of the Royal Society of Canada Panel Report (rather than the Québec Committee Report or the *Carter* decision) as the foundation for our guidelines. Like the RSC Panel and unlike the Québec Committee, we do not seek to limit access to voluntary euthanasia or assisted suicide to those who are "suffering from a serious, incurable disease", "in an advanced state of weakening capacities, with no chance of improvement", or having "constant and unbearable physical or psychological suffering that cannot be eased under conditions he or she deems tolerable."[15] We were persuaded by the arguments on limits to access presented in the RSC Panel Report and the literature grounding it, and so in this paper we are attempting to demonstrate the implications of that report for practice by rolling it out into concrete guidelines.

Third, we anticipate a possible argument that our proposed guidelines could be subject to an administrative law challenge. Section 14 of the *Criminal Code* states: "No person is entitled to consent to have death inflicted on him, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted on the person by whom consent is given."[16] The administrative law challenge could be made because our guidelines are based on an autonomous choice by the deceased for his or her life to end – this is inconsistent with the prohibition on consenting to one's own death. We consider, however, that our proposed guidelines would withstand such a challenge because they do not infringe on the criteria delineating when criminal responsibility is established as a matter of law. Instead, the proposed voluntary euthanasia and assisted suicide guidelines are relevant only to the exercise of discretion in determining whether it is in the public interest for that conduct to be prosecuted. We also note that the public interest factor of autonomous choice in the proposed guidelines would not be the sole criterion for the exercise of prosecutorial discretion, since prosecutors would also have to apply the other public interest considerations, as set out in the general prosecution guidelines.

## I. Prosecutorial Guidelines in Canada

The criminal offences that principally arise in the context of voluntary euthanasia and assisted suicide are murder; manslaughter; administering a

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Committee on Euthanasia and Assisted Suicide, June 1995), online: <www.parl.gc.ca/Content/SEN/Committee/351/euth/rep/lad-e.htm>.

[15] Québec Committee Recommendations, *supra* note 9 at 5.

[16] *Supra* note 2.

noxious thing; and aiding, abetting, or counselling suicide.[17] It is no defence that an accused's conduct was motivated by compassion,[18] nor is a person excused from criminal responsibility because a victim consented to his or her own death.[19] However, the commission of one of the above offences is not in and of itself sufficient to lead to prosecution. Prosecutors have discretion with respect to the prosecution and withdrawal of charges under the *Criminal Code*. Individual prosecutors are assisted in the exercise of this discretion through their upward reporting relationships and by instructions, guidelines, or directives (hereafter "guidelines") issued under the authority of the Director of Public Prosecutions ("DPP") or the Attorney General.[20] These guide-

[17] *Ibid* ss 229, 234, 245, 241.

[18] Motive is not relevant to determining *criminal responsibility* in these cases. Justice Dickson, as he then was, stated the general rule with respect to motive and the criminal law in *R v Lewis*, [1979] 2 SCR 821 at 831, 98 DLR (3d) 111: "In ordinary parlance, the words 'intent' and 'motive' are frequently used interchangeably, but in the criminal law they are distinct. In most criminal trials, the mental element, the *mens rea* with which the Court is concerned, relates to 'intent,' i.e., the exercise of a free will to use particular means to produce a particular result, rather than with "motive," i.e., that which precedes and induces the exercise of the will. The mental element of a crime ordinarily involves no reference to motive." That said, motive may be relevant to *sentencing* an individual. It should also be noted here that, as somewhat of an exception to the general approach taken to motive in respect of criminal responsibility, the motives of health care professionals have been taken into account in certain instances. See Joan Gilmour, "Death, Dying and Decision-Making about End of Life Care" in Jocelyn Downie, Timothy Caulfield & Colleen Flood, eds, *Canadian Health Law and Policy*, 4th ed (Toronto: LexisNexis, 2011) at 431. However, these 'instances' are explicitly distinguished from euthanasia and assisted suicide by those who embrace the exception (rather, they relate to pain management and withholding or withdrawal of potentially life-sustaining treatment).

[19] *Criminal Code*, *supra* note 2 s 14.

[20] In some jurisdictions, there is both a statutorily independent Director of Public Prosecution and an Attorney General (i.e., Nova Scotia, Québec, and at the federal level) while in others, there is no DPP or the DPP is not independent of the Attorney General. For examples of charging guidelines in various jurisdictions, see British Columbia, Prosecution Services, "Crown Counsel Policy Manual" (British Columbia: PS, 18 November 2005), online: <www.ag.gov.bc.ca/prosecution-service/policy-man/index.htm> [BC General Guidelines]; Nova Scotia, Public Prosecution Service, "Crown Attorney Manual" (Halifax: PPS, 2004), online: <www.gov.ns.ca/pps/ca_manual.htm> [NS Guidelines]; Newfoundland and Labrador, Office of the Director of Public Prosecutions, "Guidebook of Policies and Procedures for the Conduct of Criminal Prosecutions in Newfoundland and Labrador", (St. John's: ODPP, October 2007), online:

lines set out the test that the Crown will apply in considering whether to prosecute the accused. Generally, there are two considerations:

1. Whether there is sufficient evidence such that there is a reasonable prospect of securing a conviction

2. If so, whether it is in the public interest that a prosecution occur

Of significance for this article is the second consideration. The various Canadian prosecution guidelines identify a range of factors that may be relevant to determining whether a prosecution is in the public interest: the seriousness of the alleged offence; any mitigating or aggravating circumstances; the characteristics of the accused, the victim and any witnesses (such as age, physical or mental health, or disability); the degree of the accused's culpability in relation to the offence; antecedents and background of the accused; the prevalence of this type of offence and the need for deterrence; the level of public concern about the offence; the attitude of the victim with regards to prosecution; the level of co-operation from the accused; the need to maintain confidence in Parliament, the courts, and the law; public order and morale; the likely sentence if the accused is convicted; and the likely length and cost of trial.[21]

Although some of these factors may have particular applicability to cases involving voluntary euthanasia and assisted suicide, only the Province of British Columbia has developed guidelines that explicitly address such cases. However, the bulk (>90% of the text) of the BC Guidelines is directed at providing guidance under the heading of "substantial likelihood of conviction"[22] with respect to the characterization of "the conduct of the person involved in a death"[23]; in particular, the Guidelines clearly delineate the following categories of conduct: euthanasia, assisted suicide, palliative care,

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<www.justice.gov.nl.ca/just/prosecutions/pp_guide_book.pdf> [NL Guidelines]; Alberta, Justice and Solicitor General, "Crown Prosecutors' Policy Manual" (Edmonton**:** JSG, 15 January 2009), online: <justice.alberta.ca/programs_services/criminal_pros/Publications%20Library%20%20Criminal%20Prosecutions/Crown Prosecutors%27PolicyManual.aspx/DispForm.aspx?ID=3> [AB Guidelines]; Ontario, Ministry of the Attorney General, "Crown Policy Manual" (Toronto**:** MAG, 2005), online: <www.attorneygeneral.jus. gov.on.ca/english/crim/cpm/default.asp> [ON Guidelines].

[21] *Ibid.*

[22] BC Guidelines, *supra* note 11 at 1.

[23] *Ibid*.

and withholding or withdrawing treatment. The characterization of the conduct is critical because the guidelines clearly state that euthanasia and assisted suicide are offences under the *Criminal Code*, while each of palliative care and the withholding or withdrawal of treatment, "when provided or administered according to accepted ethical medical standards," are "not subject to criminal prosecution."[24] Euthanasia and assisted suicide are clearly, under these guidelines, subject to criminal prosecution in BC. In the remaining <10% of the text of the guidelines, under the heading "Public interest"[25], three factors are set out to provide guidance with respect to when the public interest requires prosecution: "1) the importance of supporting proper professional and ethical standards within the health care professions; 2) society's interest in the protection of vulnerable persons; and 3) society's interest in protecting the sanctity of human life, recognizing this does not require life to be preserved at all costs."[26] Of note is the fact that these three factors are expressed in terms that are usually relied upon by those arguing against permitting voluntary euthanasia and assisted suicide. This suggests that, to the extent these public interest factors are relevant to a particular case, their application would tend in favour of prosecution. In sum, the BC Guidelines clarify what is already permitted and what is not, rather than expanding what is permitted.

In light of this, the BC Guidelines should not be taken as sufficient to meet the recommendations made by the Québec Committee or the RSC Panel. They do not carve out at least some cases of medical aid in dying or voluntary euthanasia and assisted suicide as not being appropriately subject to prosecution. The BC guidelines do not establish circumstances within which voluntary euthanasia and assisted suicide would not be prosecuted, but rather distinguish conduct that would not be prosecuted (palliative care and withholding or withdrawal of treatment) from conduct that would (all cases of euthanasia and assisted suicide, and those cases of palliative care and withholding or withdrawal that were not provided or administered according to accepted ethical medical standards).

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[24] *Ibid* at 2.

[25] *Ibid* at 4.

[26] *Ibid*.

## II. Prosecutorial Guidelines in England and Wales

England and Wales recently produced prosecutorial guidelines dealing with assisted suicide (the guidelines do not cover voluntary euthanasia).[27] This occurred after the final judicial decision of the House of Lords in July 2009: *R. (on the application of Purdy) v Director of Public Prosecutions.*[28] Ms. Purdy suffered from primary progressive multiple sclerosis and wished to obtain assistance from her husband to travel to a jurisdiction where assisted suicide was lawful so that she might die. She was, however, concerned that her husband might be prosecuted and so she requested information from the DPP as to the factors he would consider when deciding whether to consent to the initiation of a prosecution for assisted suicide. This consent is specifically required by section 2(4) of the *Suicide Act 1961* (UK). The DPP declined to provide that information, and Ms. Purdy challenged that decision. The House of Lords concluded that Ms. Purdy was entitled to know what factors the DPP would consider when deciding whether or not to prosecute, and directed him to promulgate an offence-specific policy to this effect.

In reaching this conclusion, the House of Lords considered that Ms. Purdy's right to respect for her private life under article 8(1) of the *European Convention for the Protection of Human Rights and Fundamental Freedoms*[29] was engaged. A failure to provide an offence-specific policy setting out the factors that will be used to determine whether a prosecution is in the public interest interfered with that right in a manner that was not "in accordance with law" as required by article 8(2). Of significance for the House of

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[27] England and Wales Guidelines, *supra* note 12.

[28] *R (on the application of Purdy) v Director of Public Prosecutions,* [2009] UKHL 45, [2010] 1 AC 345 [*Purdy*]. The case of *R (on the application of Pretty) v Director of Public Prosecutions*, [2001] UKHL 61, [2002] 1 AC 800 [*Pretty*] also dealt with the issue of prosecutorial discretion in the context of assisted suicide. We do not discuss this case here, as it is *Purdy* that ultimately triggered the England and Wales Guidelines, and it is these Guidelines that we considered, drew upon, and distinguished from ours.

[29] *Convention for the Protection of Human Rights and Fundamental Freedoms*, opened for signature 4 November 1950, 213 UNTS 221 (entered into force 3 September 1953), as amended by *Protocol No 14 to the Convention for the Protection of Human Rights and Fundamental Freedoms, Amending the Control System of the Convention*, art 8(1), opened for signature 13 May 2004, CETS No 194 (entered into force 1 June 2010).

Lords was that the general "Code for Crown Prosecutors"[30] provided inadequate guidance as to when cases of this type would be prosecuted. The court also noted the disparity between the prohibition on assisted suicide and the general practice in terms of prosecutions actually brought. These factors meant that Ms. Purdy, and those who might assist her, such as her husband, were not able to make decisions about how to conduct themselves in accordance with the criminal law. Further offence-specific guidance was therefore needed from the DPP.

In September 2009, the DPP produced an interim policy setting out proposed factors for and against the prosecution of cases of assisted suicide.[31] That policy was then the subject of a wide public consultation process which included the participation of over 4,700 individuals and organisations.[32] In February 2010, after considering the results of that consultation exercise, the DPP published its final *Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide*.[33] In determining whether a prosecution is in the public interest, the guidelines set out 16 factors that favour prosecution and six factors that tend against it.

The public interest factors tending in favour of prosecution are:[34]

1. the victim was under 18 years of age;

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[30] England and Wales, Crown Prosecution Service, "The Code for Crown Prosecutors" (London: CPS, February 2010), online: <www.cps.gov.uk/publications/docs/code2010english.pdf>.

[31] See England and Wales, Director of Public Prosecutions, "Interim Policy for Prosecutors in Respect of Cases of Assisted Suicide", by the Crown Prosecutions Service (London: DPP, September 2009), online: <www.cps.gov.uk/consultations/as_policy.pdf> [England and Wales Interim Policy Consultation].

[32] See England and Wales, Director of Public Prosecutions, *Public Consultation Exercise on the Interim Policy for Prosecutors in respect of Cases of Assisted Suicide: Summary of Responses*, by the Crown Prosecution Service (London: DPP, February 2010), online: <www.cps.gov.uk/consultations/as_responses.pdf> [England and Wales Interim Policy Summary]. See also England and Wales Interim Policy Consultation, *supra* note 32.

[33] England and Wales Guidelines, *supra* note 12. Note also that the Isle of Man has recently followed suit and issued guidelines in similar terms, see "Suicide policy same as UK", *Isle of Man News* (28 September 2011), online: Isle of Man Today <www.iomtoday.co.im/news/isle-of-man-news/suicide_policy_same_as_uk_1_3814031>.

[34] England and Wales Guidelines, *supra* note 12 at para 43.

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;[35]

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;

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;

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[35] The guidelines later clarify that a common sense approach should be taken in relation to this factor. Some benefit may accrue to the suspect from the victim's death but the critical element is the suspect's motive: England and Wales Guidelines, *ibid* at para 44.

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 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;

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.

The public interest factors tending against prosecution are:[36]

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.

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[36] England and Wales Guidelines, *supra* note 12 at para 45.

There is a growing body of academic work that examines the England and Wales Guidelines.[37] There is not space in this paper to rehearse that literature, nor is it our goal to undertake a detailed critique of the guidelines themselves. To contextualise our recommendations, however, we do make four brief observations that inform our alternative approach, and lead to points of disagreement and thereafter divergence between our guidelines and those in England and Wales.

The first observation is that the guidelines do not appear to be founded on a set of coherent guiding principles. This seemed to be confirmed by evidence given by the DPP responsible for developing the guidelines, Keir Starmer, to the privately established Commission on Assisted Dying.[38] In response to a question about what the "underlying principle" was for the guidelines, he noted that a "schematic approach" had been avoided on the basis

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[37] See for example, Penney Lewis, "Informal Legal Change on Assisted Suicide: The Policy for Prosecutors" (2011) 31 LS 119; JJ Shaw, "Fifty Years On: Against Stigmatising Myths, Taboos and Traditions Embedded Within the Suicide Act 1961 (UK)" (2011) 18 J Law Med 798; Glenys Williams, "Assisting Suicide, the Code for Crown Prosecutors and the DPP's Discretion" (2010) 39:2 C L World Rev 181; John Finnis, "Invoking the Principle of Legality Against the Rule of Law" (2010) Part IV NZL Rev 601; Carol C Cleary, "From 'Personal Autonomy' to 'Death-on-Demand': Will *Purdy v DPP* Legalize Assisted Suicide in the United Kingdom?" (2010) 33 BC Int'l & Comp L Rev 289; Rob Heywood, "The DPP's Prosecutorial Policy on Assisted Suicide" (2010) 21 King's Law Journal 425; John Coggon, "Prosecutorial Policy on Encouraging and Assisting Suicide – How Much Clearer Could It Be?" (2010) 36 J Med Ethics 381; Jonathan Rogers, "Prosecutorial Policies, Prosecutorial Systems, and the *Purdy* Litigation" (2010) Issue 7 Crim L Rev 543; Roger Daw & Alex Solomon, "Assisted Suicide and Identifying the Public Interest in the Decision to Prosecute" (2010) Issue 10 Crim L Rev 737; Alexandra Mullock, "Overlooking the Criminally Compassionate: What Are the Implications of Prosecutorial Policy on Encouraging or Assisting Suicide" (2010) 18 Med L Rev 442; Suzanne Ost, "The De-Medicalisation of Assisted Dying: Is a Less Medicalised Model the Way Forward?" (2010) 18 Med L Rev 497; Clive Seale, "Do It Properly or Not at All" (2010) 340 BMJ 775; John Coggon, "Doctors and Assisted Suicide" (2010) 340 BMJ 547. Although not in the academic context, see also the detailed examination of the England and Wales Guidelines in The Commission on Assisted Dying, "The Current Legal Status Of Assisted Dying Is Inadequate and Incoherent...", online: Demos see especially pp 89-105 <www.demos.co.uk/files/476_CoAD_FinalReport_158x240_I_web_single- NEW_.pdf?1328113363>.

[38] More information about the Commission on Assisted Dying is available online: <www.commissiononassisteddying.co.uk/about-the-commission-for-assisted-dying>.

that such an approach would risk, "unless it's very carefully constructed, undermining Parliament's intention that this should be an offence."[39] The role of the DPP was instead, he explained, to exercise discretion on a case-by-case basis. The risk of this approach, however, is that the guidelines may not be conceptually sound and may lead to undesirable outcomes in practice. Consider, for example, the factor in favour of prosecution that the suspect was aware that the deceased intended to commit suicide in a public place where people may be present. It is clear that this factor is different in character to the others in the guidelines and seems to be aimed at different considerations. We ultimately omitted this factor from our guidelines because it did not flow from the guiding principles we established as relevant for our approach. We were also concerned that it may inadvertently capture places where we would argue it could be appropriate for voluntary euthanasia or assisted suicide to occur, such as a hospital room which, at least sometimes, is a "public place."[40] Nevertheless, depending on the starting point of the analysis, such a factor could be regarded as appropriate. However, without a clear articulation of relevant guiding principles, it is unclear whether this is so, and what purpose this factor is serving.[41]

The second observation is linked to the first: the authors of the guidelines failed to articulate the significance of, and the relationship between, the various factors in the guidelines.[42] For example, as we outline below when con-

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[39] Commission on Assisted Dying, *Transcript of Evidence from Keir Starmer QC, Director of Public Prosecutions* (14 December 2010) at 17, online: Commission on Assisted Dying <commissiononassisteddying.co.uk/wp-content/uploads/2010/12/Keir-Starmer-Transcript-Final1.pdf> [Keir Starmer Transcript].

[40] We also note that there are public order offences that are capable of addressing this concern in a more nuanced fashion.

[41] It could reflect an attempt to prevent harm to third parties who witness the assisted suicide or voluntary euthanasia. The language is both so under-inclusive and over-inclusive that it would not achieve this objective. It could capture individuals in a public place, such as a hospital room, where no innocent third parties will be harmed, and it could also fail to capture individuals in a private place, where third parties will be harmed by discovering the body. Location seems to be a poor proxy for some consequences one might legitimately seek to prevent.

[42] A similar critique is made in relation to the various elements of the "public interest" test of the "Code for Crown Prosecutors" (*supra*, note 31) in Jonathan Rogers, "Restructuring the Exercise Of Prosecutorial Discretion in England" (2006) 26 Oxford J Legal Stud 775 at 793-94. The interim policy did suggest some factors be given greater weighting than others but this was ultimately removed, to make

structing our approach, some factors are considerations in their own right. An illustration from the England and Wales Guidelines is that "the victim had not reached a voluntary, clear, settled and informed decision to commit suicide."[43] By contrast, other factors might best be described as "evidential," that is, they are evidence as to whether or not other factors in the guidelines will be substantiated. A relevant England and Wales example is whether or not "the suspect pressured the victim to commit suicide,"[44] as this in turn becomes evidence that is directly related to another factor: the voluntary nature of the decision. This distinction matters, since consistent and considered decision making requires an understanding of the role and significance of the relevant factors in a process of deliberation. We acknowledge that the guidelines note that assessing the public interest is not a numerical exercise and that prosecutors "must decide the importance of each public interest factor in the circumstances of each case and go on to make an overall assessment."[45] However, we consider this sort of guidance to still fall short of articulating, in a meaningful way, how the factors are to be used in a decision making process.

The third observation is that the England and Wales Guidelines apply only to assisted suicide and do not deal with voluntary euthanasia. Although this is the case because the guidelines were produced in response to the *Purdy* decision (which focused exclusively on assisted suicide), we consider that differentiating between voluntary euthanasia and assisted suicide is not justifiable for four reasons.[46] Firstly, to differentiate discriminates on the ba-

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the policy "clearer and more accessible" (England and Wales Interim Policy Summary, *supra* note 33 at 18, 20, 32, 34).

[43] England and Wales Guidelines, *supra* note 12 at para 43.

[44] *Ibid* at para 43.

[45] *Ibid* at para 39.

[46] While we can only provide a very brief justification for our position here, we note that the RSC Panel (*supra* note 4 at 100) and Smith J in *Carter* (*supra* note 6 at para 1393) included both voluntary euthanasia and assisted suicide in their permissive regimes. The Québec Committee Report seems to draw a distinction and include only euthanasia within "medical aid in dying": "assisted suicide, considered an individual act in time and space, does not reflect the values of medical support and safety that are inseparable from the medical aid in dying option, as we propose it. Moreover, assisted suicide certainly cannot be considered a form of care and therefore runs counter to one of the main principles that guided our thinking and our recommendations, namely that any openness in this regard should be situated in the context of a continuum of care." (*supra* note 5 at 79) To this statement we would simply respond that it is not the suicide that needs to fit

sis of disability. If the guidelines do not include voluntary euthanasia, a person whose disability or illness means that he or she is not capable of ending life on his or her own (and so requires another to do the final act that ends his or her life), may be deprived of that assistance because of concerns about prosecution.[47] Second, given that we argue for guidelines grounded in respect for autonomy, both assisted suicide and voluntary euthanasia are justified (even though the final agent of death is different). Third, a false assumption that sometimes underpins treating assisted suicide differently from voluntary euthanasia is that the former is *always* less serious than the latter. Including both in the guidelines allows prosecutors to assess whether a prosecution is appropriate in the circumstances of each case. Furthermore, as noted below, this assessment would occur not only having regard to the offence-specific guidelines, but also the general prosecutorial charging guidelines which take into account factors such as the level of culpability of the accused. Finally, we accept that some people may say that they would experience an emotional difference between assisting another person to commit suicide and participating in voluntary euthanasia.[48] However, different emotional reactions do not provide a foundation for a claim of there being a morally significant distinction – particularly a distinction to be used as the basis for public policy. Otherwise, of course, the fact that some people experience withholding treatment and withdrawing treatment differently could justify permitting one and not the other. In the context of public policy grounded in respect for autonomy, in most circumstances, the emotional difference could justify a person, such as a medical or other health professional, not being forced to provide both assisted suicide and voluntary euthanasia (autonomy is often constrained where its exercise would result in harm to others). It could not, however, justify a difference in public policy with respect to the permissibility of one and not the other.[49]

The final observation is concerned with the emphasis the England and Wales Guidelines place on the conduct of the suspect being characterized as

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within the "continuum of care" but rather the provision of assistance and the provision of a prescription for a lethal medication, arguably, fits as well within the continuum of care as does provision of a lethal injection.

[47] Margaret Otlowski, *Voluntary Euthanasia and the Common Law* (Oxford: Clarendon Press, 1997) at 194-95.

[48] Ilinka Haverkate et al, "The Emotional Impact on Physicians of Hastening the Death of a Patient" (2001) 175 Med J Aust 519.

[49] Otlowski, *supra* note 48. See also, for example, Dan Brock, "Voluntary Active Euthanasia" (1992) 22:2 The Hastings Center Report 10.

non-professional, "compassionately-motivated one-off assistance."[50] Related to this, the guidelines specifically discourage the involvement of medical and other health professionals as well as individuals belonging to organizations that facilitate assisted suicide. Such an approach gives rise to concerns that, without the relevant expertise and experience, incorrect assessments of the deceased's competence might be made.[51] Also of concern is the fact that attempts by the unqualified to assist the deceased may lead to the latter dying in pain or discomfort, or experiencing the indignity in death that he or she was seeking to avoid.[52] Further, precluding the involvement of medical and other health professionals may also reduce the deceased's opportunity to make a decision about whether to die in light of complete and accurate information about his or her prognosis and treatment options.[53] For these reasons, our proposed guidelines do not treat acting in a professional capacity in and of itself as a factor in favour of prosecution.[54] We note finally that this aspect of the England and Wales Guidelines is the subject of legal challenge by a man who wishes to end his life but whose family would not assist him. "Martin" is challenging the guidelines seeking that they be "clarified" so that he could be helped by "a member of the public … , a health professional or a solicitor."[55]

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[50] England and Wales Interim Policy Consultation, *supra* note 32. See also comments in Keir Starmer Transcript, *supra* note 40 at 7-8, 10. See also Williams, *supra* note 38 at 192-93 and Mullock, who notes the significant weight given to this consideration (*supra* note 38).

[51] Lewis, *supra* note 38 at 129. Although there are aspects of assessing whether decision making is competent and voluntary that do not require medical expertise (for example, the impact of family dynamics), medical involvement in capacity assessments is likely to reduce error (Ost, *supra* note 38 at 534-37).

[52] Lewis, *supra* note 38 at 129-30; Seale, *supra* note 32; Ost, *supra* note 38 at 534-37; Mullock, *supra* note 38 at 452-53; Commission on Assisted Dying, *supra* note 32 at 98-99.

[53] Ost, *supra* note 38 at 537.

[54] This is consistent with the RSC Panel, which recommended "health care professionals be permitted to provide assistance with suicide or voluntary euthanasia" (RSC Panel Report, *supra* note 4 at 101). The Québec Committee Report (*supra* note 5 at 82) and Madam Justice Smith (*Carter*, *supra* note 6 at para 1393) both limit permissible assistance to physicians.

[55] Clare Dyer, "Nicklinson's Widow is Refused Right to Appeal to Higher Court" (2012) 345 Brit Med J e6690. "Martin" received leave to appeal against the English High Court's conclusion in *R (on the application of Nicklinson) v Ministry of Justice; R (on the application of AM) v Director of Public Prosecutions* [2012]

## III. Proposed Voluntary Euthanasia and Assisted Suicide Guidelines

### *1. Introduction*

We turn now to setting out our proposed guidelines for when prosecutions should or should not occur in relation to voluntary euthanasia and assisted suicide. In this effort, we are informed by our above critiques, the academic literature and case law on prosecutorial discretion in general and charging guidelines in particular, and the arguments presented in the RSC Panel Report. Although we were not able to undertake a detailed review of the British Columbia or the England and Wales Guidelines in this paper, we consider that there are sufficient concerns about those models to warrant starting anew and designing a set of guidelines for the Canadian context, albeit informed by the experience in BC and England and Wales. As part of that process, we start from first principles and identify three guiding principles for constructing these guidelines: respecting autonomous choice, promoting high-quality decision making by prosecutors, and ensuring public confidence in the decisions of prosecutors. Each of these principles is discussed in more detail below.

Having identified those principles, we are then in a position to determine the content of the guidelines, which we have organized into six components. The first component states that a public interest factor that tends in favour of, or against, prosecution is whether the deceased's death occurred as a result of an autonomous choice made by the deceased for his or her life to end.[56] The second and third components of the guidelines deal with how the nature of the deceased's choice (if any) is to be established: what are the elements of an autonomous choice in the context of voluntary euthanasia and assisted suicide, and what is the evidence that may be directly relevant to determining whether those elements are present or not. For example, one element of an autonomous choice is that it was made voluntarily, and direct evidence of whether that is the case or not might include whether the suggestion to consider voluntary euthanasia or assisted suicide came from the deceased or

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EWHC 2381 that the DPP was not required to clarify his policy as requested. Martin's case was heard along with the related case of Tony Nicklinson (who challenged the law rather than the DPP policy). Nicklinson was unsuccessful before the High Court and his widow (Nicklinson had subsequently died) was denied leave to appeal: Dyer above.

[56] We use the language of "tends in favour, or against" because some discretion is needed (otherwise the guidelines shift to favour ceasing to apply the law with obvious consequences for the rule of law).

from the suspect. The fourth component is comprised of factors that do not constitute direct evidence of whether the elements of an autonomous choice are present or not, but that nevertheless give confidence or raise doubts as to the nature of the choice. An example of this is where the suspect has a financial interest in the death of the deceased. While in such cases it is still possible to show that, as a matter of fact, an autonomous choice has been made, the mere presence of this factor creates a real risk that this may not be the case. Recognition of such "confidence factors" in the guidelines is important in individual cases but also in the longer term for ensuring that the public has confidence in these decisions and that these guidelines do not foster situations where non-autonomous choices are acted upon.

These four components comprise the decision making content of the offence-specific guidelines, and explain how a prosecutor should use each component in his or her decision making. Although this is explained further below when each component is considered in more detail, we have briefly indicated here the role played by each of the components and how they relate to each other. This is important in light of the objection expressed earlier asserting that the England and Wales Guidelines fail to articulate the significance of, and the relationship between, the various factors in those guidelines. We anticipate the suggestion that in practice, such decision making may not be as nuanced and orderly as our approach. Nevertheless, deficits in practice do not detract from the importance of conceptual clarity in decision making and there is merit in attempting to articulate how decisions should be made in a principled way.

The final two components relate more to process issues of decision making than to the content of those decisions. The fifth component requires that decisions regarding whether or not to prosecute under the guidelines be made with the consent of the relevant Attorney General himself or herself. The sixth component establishes a reporting structure for decisions whether or not to prosecute. Reporting should occur in relation to individual decisions but systematic data should also be kept and published to ensure the system is, and is seen to be, working.

It should be noted that our guidelines contemplate roles for both prosecutors and the Attorney General. The first four components will, in the first instance, be investigated and assessed by prosecutors. The fifth and sixth components are the responsibility of the Attorney General. However, in undertaking these latter roles, the Attorney General must also engage with the first four components. To illustrate, engaging with whether or not the deceased's life ended as a result of an autonomous choice is essential when deciding

whether or not to prosecute and why. In doing so, the Attorney General would have regard to the advice of prosecutors who have conducted investigations and formed views as to these matters although the ultimate decision as to whether a prosecution occurs remains with the Attorney General. For ease of reference, the discussion that follows of "prosecutors" in relation to the first four components will, except where the context indicates otherwise, include both prosecutors (as they have responsibility for these matters in the first instance), and the Attorney General (as the person charged with ultimate prosecutorial decision making responsibility).

Turning finally to the scope and operation of the proposed guidelines: they are intended not to exclude, but to supplement the operation of the general prosecutorial guidelines. Prosecutors would be required to apply the broader public interest considerations in the general guidelines as well as the additional public interest factor identified as significant for these specific offences set out below.[57] Our guidelines also apply only where the deceased was capable of making an autonomous choice for his or her life to end (that is, competent adults and mature minors alike, as discussed below).[58] Given the centrality of autonomy in these guidelines, it is not appropriate that they govern adults or children who are incompetent. Finally, for the reasons outlined above,[59] the guidelines apply to both voluntary euthanasia and assisted suicide. We note though that the operation of the general prosecutorial guidelines may be significant in terms of how these two situations are treated. As noted above,[60] some of the factors in the general guidelines to be considered in assessing whether prosecution is in the public interest include the seriousness of the alleged offence and the degree of culpability of the accused. It may be that in particular cases of voluntary euthanasia the greater level of participation by the accused in the deceased's death points more towards prosecution than if he or she had only assisted the deceased's suicide. That will not always be the case, however, and allowing the guidelines to deal with both situations allows this discretion to be exercised in light of the facts of each case.

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[57] This is also the approach taken in England and Wales Guidelines, *supra* note 12 at para 38.

[58] See below at "Capacity".

[59] See above at "Prosecutorial Guidelines in England and Wales".

[60] See above at "Prosecutorial Guidelines in Canada".

### *2. Three Guiding Principles*

In drafting the proposed prosecutorial guidelines, we were guided by three principles:

1. the critical factor that tends against prosecution is if the deceased's death occurred as a result of an autonomous choice made by the deceased for his or her life to end;

2. the decision making pursuant to the prosecutorial discretion in this area needs to be of high-quality; and

3. the decision making pursuant to that discretion needs to attract public confidence.

We consider each in turn.

*Guiding Principle One: An Autonomous Choice*

One can find support in law for the consideration of autonomy as an appropriate value underpinning these guidelines.[61] The principle of autonomy in the medical treatment context is of fundamental importance in Canadian common law and is enshrined in the *Charter of Rights and Freedoms*.[62] As Robins, JA noted for the Ontario Court of Appeal in the well-known case of *Fleming v Reid*:

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[61] Of course, support for this idea can also be found in ethics. We do not, however, rely upon an ethical argument for respect for autonomy here. This is in part because we believe that the argument can be made without introducing the complexity and controversy associated with competing ethical theories about autonomy (contrast, for example, the conceptions of autonomy articulated in Immanuel Kant, *Fundamental Principles of the Metaphysics of Morals* (1785); John Stuart Mill, *On Liberty* (1859), online: Bartleby <www.bartleby.com/25/2>; and Susan Sherwin, "Relational Autonomy and Global Threats" in Jocelyn Downie & Jennifer Llewellyn, eds, *Being Relational: Reflections on Relational Theory and Health Law* (Victoria: University of British Columbia Press, 2011). We believe that it is necessary and sufficient to ground the guidelines proposed in this article in the conventional understanding of autonomy that underpins the law more generally. The guidelines can and should evolve insofar as the law evolves in relation to changing conceptions of autonomy within moral philosophy. We do not see the project in this article as contributing to or driving such change.

[62] *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11.

> The common law right to bodily integrity and personal autonomy is so entrenched in the traditions of our law to be ranked as fundamental and deserving of the highest order of protection. This right forms an essential part of an individual's security of the person and must be included in the liberty interests protected by s. 7 [of the Canadian *Charter of Rights and Freedoms*]. Indeed, in my view, the common law right to determine what shall be done with one's own body and the constitutional right to security of the person, both of which are founded on the belief in the dignity and autonomy of each individual, can be treated as co-extensive.[63]

In light of its recognition by Canadian law, we consider that respect for autonomy is an appropriate guiding principle to inform our approach to drafting guidelines that outline when prosecution may or may not be in the public interest. Therefore, as argued below, we consider that the critical factor that tends against prosecution in such cases is if the deceased's death occurred as a result of an autonomous choice made by the deceased for his or her life to end.[64]

*Guiding Principle Two: High-quality Decision Making*

A decision regarding whether or not to prosecute cases potentially involving voluntary euthanasia and assisted suicide is significant. Most obviously, whether a prosecution occurs in relation to a death is significant for the deceased. For example, a choice not to prosecute on public interest grounds means the taking of the deceased's life does not, in all of the circumstances, warrant criminal sanctions. While in some instances such an outcome would be as the deceased had hoped, in other circumstances such a decision could be regarded as a failure to acknowledge the wrongful nature of the death. The decision is also significant for the suspect (who may also be a member of the deceased's family or a friend). A decision to prosecute imposes the "harms of prosecution"[65] on the suspect, and he or she also faces the prospect of conviction for a serious criminal offence, potentially murder, which carries a mandatory life sentence in Canada. Finally, it is significant for society as a whole: the ending of another person's life matters for the

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[63] [1991] OJ No 1083, 4 OR (3d) 74 (Ont CA) at paras 30-36.

[64] This argument is made in greater depth and at greater length in the RSC Panel Report, *supra* note 4. We rely on that text (particularly chapter three) as further explanation and justification for the foundation of our proposed guidelines.

[65] Rogers, *supra* note 43 at 787-91.

community,[66] and so determining the appropriate criminal law response is important. It is therefore critical that decisions regarding whether or not to prosecute in such cases be of high-quality. For the purposes of this article, we consider high-quality decision making to require a process that is rigorous, transparent, and accountable, and that results in outcomes that accurately reflect conceptually sound criteria (which here we put forward in our proposed guidelines). This is particularly so given that such decisions are not susceptible to judicial review in Canada, except to prevent an abuse of process.[67]

The production of clear guidelines dealing with the exercise of prosecutorial discretion in relation to cases of voluntary euthanasia and assisted suicide is one way to promote high-quality decision making. As discussed above in *Purdy*, clear guidelines provide a basis for ensuring whether decisions to prosecute are made predictably and consistently.[68] This is a function of prosecution guidelines generally,[69] and this claim can also be made in relation to those designed for specific offences. Making the guidelines publicly available also helps promote high-quality decision making as prosecutorial decisions (even in the absence of reasons for those decisions as discussed below) can attract a certain level of scrutiny that can be referenced against those criteria.[70]

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[66] The purposes and principles of sentencing outlined at section 718 of the *Criminal Code* explicitly recognize that criminal conduct harms both the victim and the community at large. With respect to homicide in particular, Kilpatrick J noted in *R v VanEindhoven*, 2007 NUCJ 2 at para 64, [2007] NuJ no 2 (QL): "As a family, as a community, as a people we are all diminished when a life is taken from us prematurely."

[67] *R v Power*, [1994] 1 SCR 601, [1994] SCJ no 29 (QL).

[68] *Purdy*, *supra* note 29 at 395 (Lord Hope of Craighead).

[69] See e.g. ON Guidelines, *supra* note 21; Alberta, Justice and Solicitor General, "Decision to Prosecute, The Criteria Governing the Decision to Commence or Continue Prosecution" in "Alberta Crown Prosecutors' Policy Manual" (Edmonton: JSG, 20 May 2008), online: <justice.alberta.ca/programs_services/criminal_pros/crown_prosecutor/Pages/decision_to_prosecute.aspx>.

[70] Andrew Ashworth, "The 'Public Interest' Element in Prosecutions" (1987) Issue 9 Crim L Rev 595 at 605-06; Keir Starmer Transcript, *supra* note 40 at 4; Marc Rosenberg, "The Attorney General in the 21st Century: A Tribute to Ian Scott: The Attorney General and the Administration of Criminal Justice" (2009) 34 Queen's LJ 813.

The terms of the guidelines themselves can also establish ways in which high-quality decision making in this area can be promoted. One is by ensuring there is rigour in the decision making process, and the requirement to produce reasons for decisions can help to achieve that.[71] Another is by advocating an open approach to the exercise of the prosecutorial discretion and making those reasons for decisions publicly available so that decision making is transparent and accountable to the community.[72] Developing monitoring systems of longer term trends to ensure the efficacy of the guidelines and decision making pursuant to them can also ensure that the discretion is being exercised to a high standard.[73] The terms of the guidelines can also support high-quality decision making by requiring that the Attorney General consent to a prosecution whether a prosecution occurs or not.[74]

*Guiding Principle Three: Public Confidence in Exercise of Prosecutorial Discretion*

The third guiding principle that informs our proposed guidelines is that they, and the decisions made pursuant to them by prosecutors, need to retain public confidence. As noted above, these are significant decisions in a complex and contested area and so it is important that the public has confidence in how they are made.[75] While this guiding principle is related to the previ-

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[71] David Phillip Jones & Anne S de Villars, *Principles of Administrative Law*, 5th ed (Toronto: Carswell, 2009) at 372-73; Sara Blake, *Administrative Law in Canada*, 5th ed (Markham: LexisNexis Canada, 2011) at 92.

[72] Ashworth, *supra* note 71 at 605-06. This is why the current England and Wales DPP, Keir Starmer QC, states that he makes publicly available reasons for decisions not to prosecute in cases that are already in the public domain (Keir Starmer Transcript, *supra* note 40 at 4).

[73] While not gathered in relation to prosecutorial guidelines of the sort advocated for in this article, the systemic data collected in the Netherlands have, for example, highlighted issues of concern that have then been able to be demonstrably addressed through changes to law and practice. See e.g. the discussion of changing reporting requirements and rates in Judith AC Rietjens et al, "Two Decades of Research on Euthanasia from the Netherlands. What Have We Learnt and What Questions Remain?" (2009) 6:3 J Bioeth Inq 271 at 279.

[74] See below "Component Five: Decision Consented to by the Attorney General".

[75] Daw & Solomon, *supra* note 38 at 742, 750-51; Jeremy Rapke, "*R (Purdy) v DPP* – Its Implications for Prosecuting Authorities" (Paper delivered at the Conference of Australian and Pacific Prosecutors, October 2009). Some of the provincial prosecutorial guidelines explicitly recognize that wrongly exercising prosecutorial discretion undermines public confidence in the criminal justice system. See for

ous one, in that high-quality decision making can attract public confidence, these principles are distinct and so warrant separate consideration. Public confidence could be had in decision making that is not of a high standard, and high-quality decision making will not always attract public confidence.

One way to earn public confidence in prosecutorial decision making is through openness. As noted above, the public availability of the guidelines can make decision making more transparent, which can engender public confidence in the exercise of prosecutorial discretion.[76] There is also scope for the guidelines to impose requirements designed to promote public confidence. Requiring decisions to be made publicly available enables the public to scrutinize the exercise of the discretion and discretion – if exercised appropriately – will attract public confidence.[77] A similar argument applies to making publicly available systemic data about how the guidelines are being used.[78] Requiring the Attorney General to consent to the decision as to

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example, Nova Scotia, Public Prosecution Service, "The Decision to Prosecute (Charge Screening)" (Halifax: PPS, 1 February 2011) at 2, online: <www.gov.ns.ca/pps/publications/ca_manual/ProsecutionPolicies/DecisionToProsecute.pdf>; Newfoundland and Labrador, Office of the Director of Public Prosecutions, "Communications with the Media" in "Guidebook of Policies and Procedures for the Conduct of Criminal Prosecutions in Newfoundland and Labrador" (St. John's, ODPP, October 2007) at 10-1, online: <www.justice.gov.nl.ca/just/prosecutions/pp_guide_book.pdf>; Justice and Public Safety, "Guide Book of Policies and Procedures for the Conduct of Criminal Prosecutions in Prince Edward Island" by the Crown Attorney's Office (Charlottetown: JPS, November 2009) at 9-18, online: <www.gov.pe.ca/photos/original/jps_crownconduc.pdf>. The RSC Panel also noted the importance of the maintenance of public trust in the system (albeit in the context of its discussion of a national oversight commission), *supra* note 4 at 102.

[76] Ashworth, *supra* note 71 at 605-06; Keir Starmer Transcript, *supra* note 40 at 4.

[77] Louis Blom-Cooper, "Reasons For Not Prosecuting" (2000) PL 560; Ashworth, *supra* note 71 at 605-06; Keir Starmer Transcript, *supra* note 40 at 4.

[78] For example, the public availability of data about the Netherlands, Belgium, Oregon and Washington State as to the practice of voluntary euthanasia and/or assisted suicide has made it possible for the public to see that claims about slippery slopes and risks to vulnerable groups (such as the poor, the elderly, people from ethnic backgrounds and people with disabilities) are demonstrably false. See e.g. Rietjens et al, *supra* note 74; Kenneth Chambaere et al, "Trends in Medical End-of-Life Decision Making in Flanders, Belgium 1998-2001-2007" (2011) 31:3 Med Decis Mak 500. See also data available on the websites of the Oregon Health Authority, online: <public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/index.aspx> and the Washington State Department of

whether or not to prosecute in these cases can also promote public confidence in the guidelines.

Of course, one could argue that all decisions should be made well and should attract public confidence, and that the guiding principles of high-quality decision making – and public confidence in the exercise of this discretion – should apply not only in relation to the offences being discussed in this article, but to all offences. Indeed, many of the factors identified above could be applied or adapted to other offences, particularly those of a serious nature. However, because of the nature of the conduct at issue and the novelty of the approach (effectively allowing that some instances of assisted suicide and voluntary euthanasia do not warrant prosecution), decisions as to whether or not prosecuting a case involving voluntary euthanasia or assisted

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Health, online: <www.doh.wa.gov/dwda/>. Of course there are authors who argue that there is empirical evidence of slippery slopes and risks to vulnerable groups. Evidence from these authors was introduced into court in *Carter*, *supra* note 6 listed at para 160. See e.g. John Keown, *Euthanasia, Ethics and Public Policy: An Argument Against Legalization* (New York: Cambridge University Press, 2002); Kennedy Institute of Ethics, "Care Not Killing: Considering Physician-Assisted Suicide: An Evaluation of Lord Joffe's Assisted Dying for the Terminally Ill Bill" (Georgetown University, 2006), online: <kennedyinstitute.georgetown.edu/files/Keown_report.pdf>; Emily Jackson & John Keown, *Debating Euthanasia* (Oxford: Hart Publishing, 2011); Herbert Hendin & Kathleen Foley, "Physician-Assisted Suicide in Oregon: A Medical Perspective" (2008) 106 Mich L Rev 1613; Jose Pereira, "Legalizing Euthanasia or Assisted Suicide: The Illusion Of Safeguards and Controls" (2011) 18:2 Current Oncology 38. However, following cross-examination by the plaintiff's counsel, Madam Justice Smith concluded that: "An absolute prohibition might be called for if the evidence from permissive jurisdictions showed abuse of patients, or carelessness or callousness on the part of physicians, or evidence of the reality of a practical slippery slope.

However, that is not what the evidence shows. I have found that the evidence supports the conclusion that a system with properly designed and administered safeguards could, with a very high degree of certainty, prevent vulnerable persons from being induced to commit suicide while permitting exceptions for competent, fully-informed persons acting voluntarily to receive physician-assisted death" (*Carter*, *supra* note 6 at 1365-66). Furthermore, a rebuttal of Jose Pereira's paper was recently published in Current Oncology (the same journal that published his paper), and the journal contemporaneously acknowledged that his paper was an "opinion" rather than a peer-reviewed paper and issued a correction: Jocelyn Downie et al, "Pereira's Attack On Legalizing Euthanasia Or Assisted Suicide: Smoke and Mirrors" (2012) 19:3 Current Oncology 133 and Jose Pereira, "Erratum: Legalizing Euthanasia Or Assisted Suicide: The Illusion Of Safeguards and Controls" (2012) 19:3 Current Oncology e227.

suicide is in the public interest can give rise to a particularly high level of community interest, and sometimes concern.[79] We therefore believe it to be especially important to explicitly articulate these guiding principles here.

### *3. Six Components*

*Component One: An Additional Public Interest Factor - Autonomous Choice*

As outlined above, respect for autonomy is one of the guiding principles we used when constructing the proposed prosecutorial guidelines, and whereas high-quality decision making and public confidence are directed at least in part to procedural matters, respect for autonomy makes a greater contribution to determining the content of the guidelines. Accordingly, we place autonomy at the centre of our approach and identify whether the deceased's death occurred as a result of his or her autonomous choice as the sole additional public interest factor. As noted above, this does not preclude consideration of the broader public interest factors contained in the general prosecutorial guidelines. Rather, these proposed guidelines add a factor for prosecutors to consider that is specifically tailored for this context.

**Guidelines text**

**Autonomous Choice: an Additional Public Interest Factor Specific to These Offences**

An additional public interest factor that tends against prosecution is that the deceased's death occurred as a result of an autonomous choice made by the deceased for his or her life to end.

An additional public interest factor that tends in favour of prosecution is that the deceased's death did not occur as a result of an autonomous choice made by the deceased for his or her life to end.

*Components Two and Three: Elements and Direct Evidence of an Autonomous Choice*

In this section, we develop the second and third components of the proposed guidelines. The second component identifies how the nature of the deceased's choice is to be established (through the satisfaction of three elements) and the third component sets out an inclusive list of the direct evi-

[79] For evidence of this high level of community interest and concern in the England and Wales, see England and Wales Interim Policy Summary, *supra* note 33.

dence that may be relevant in assessing whether or not those three elements have been satisfied or not.

The three elements that need to be satisfied for the deceased's death to have occurred as a result of his or her autonomous choice are:

1. the deceased was capable of making the decision to end his or her life;

2. the decision was made voluntarily by the deceased; and

3. the deceased was offered sufficient information in relation to the decision to end his or her life.

These elements are derived from the law applying to the refusal of medical treatment. Although not entirely apposite to cases of voluntary euthanasia and assisted suicide, the law with respect to refusals provides a useful departure point (one, we note, that was taken by the England and Wales Guidelines).[80]

Capacity

The common law presumes that every adult is capable of making medical treatment decisions.[81] However, this presumption may be rebutted by evidence to the contrary. The test for capacity is decision specific; an individual may have the capacity to consent to a routine procedure such as a blood test but lack the necessary capacity to consent to deep brain stimulation. Capacity may also fluctuate over time.[82] An individual will be judged to have decisional capacity if that person has the ability to understand the information that is relevant to making the decision in question and the foreseeable risks and consequences of undergoing, or refusing to undergo, the proposed treatment.[83] The common law presumption of capacity does not extend to minors.

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[80] England and Wales Guidelines, *supra* note 12 at para 43(2).

[81] *C (JS) v Wren* (1986), [1987] 76 AR 118, (*sub nom C v Wren*) 35 DLR (4th) 419 (CA); *Starson v Swayze*, 2003 SCC 32 at para 7, [2003] 1 SCR 722.

[82] *Ibid* at para 118.

[83] In some provinces and territories, this test has been codified in legislation. See e.g. *Personal Directives Act*, RSA 2000, c P-6, s 1(b); *Health Care (Consent) and Care Facility (Admission) Act*, RSBC 1996, c 181, s 7 [*HCCACFAA*]; *The Health Care Directives Act*, SM 1992, c 33, CCSM c H27, s 2; *Personal Directives Act*, SNWT 2005, c 16, s1; *Hospitals Act*, RSNS 1989, c 208, s 52(2A); *Health Care*

Instead, children and adolescents are entitled to a degree of decisional autonomy commensurate with their level of maturity.[84]

Evidence that is relevant to determining whether a deceased had capacity or not includes whether he or she had a recent capacity assessment undertaken by an appropriately qualified medical or other health professional. Also relevant is whether the deceased was in need of assistance to make decisions about other aspects of his or her life. Although capacity is specific to the particular decision to be made, findings of incapacity in other realms can sometimes shed light on whether the deceased had capacity to choose for his or her life to end.

Voluntariness

Once again building upon the law that governs refusal of medical treatment, a decision to commit suicide must also be free of undue influence.[85] It is worth noting though that not all influence will be undue provided the decision remains that of the person; it is legitimate for others – such as family, friends, and doctors – to provide advice and even seek to dissuade the person.[86] Evidence relevant to the voluntary nature of the decision includes

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*Consent Act*, SO 1996, c 2, s 4(1); *Consent to Treatment and Health Care Directives Act*, RSPEI 1988, c C-17.2, s 7(1) [*CTHCDA*]; *Health Care Directives and Substitute Health Care Decision Makers Act*, SS 1997, c H-0.001, s 2(1)(b); *Care Consent Act*, SY 2003, c 21, s 6(2).

[84] In the recent case of *AC v Manitoba (Director of Child and Family Services)*, 2009 SCC 30 at para 87, [2009] 2 SCR 181, Abella J, for the majority, held that even in cases of a refusal of life-saving treatment, "a minor may be of sufficient maturity that [the distinction between] the principles of welfare and autonomy will collapse altogether and the child's wishes will become the controlling factor."

[85] *Norberg v Wynrib*, [1992] 2 SCR 226 at 28, 74 BCLR (2d) 2. A number of provinces and territories have codified the elements of consent, including voluntariness, in legislation. See e.g. *HCCACFAA*, *supra* note 84 at s 6; *Health Care Consent Act*, *supra* note 84 at s 11(1); *CTHCDA*, *supra* note 84 at s 6(1); *Care Consent Act*, *supra* note 84 at s 5.

[86] Barney Sneiderman, John C Irvine & Philip H Osborne, *Canadian Medical Law*, 3d ed (Toronto: Thomson Carswell, 2003) at 31. See also *Re T (Adult: Refusal of Treatment)* (1992), [1993] Fam 95 at 121, [1992] 4 All ER 649 (CA), where the Court of Appeal found that a woman's refusal of treatment was not binding on the treating team; Staughton LJ considered that influence will be undue only if there is "such a degree of external influence as to persuade the patient to depart from her own wishes." This case is referenced in Canadian secondary sources such as Ellen

whether there was any pressure placed on the deceased in his or her decision making: whether the suggestion for taking such steps originally came from the deceased, and whether there was a clear and unequivocal request from the deceased for assisted suicide or voluntary euthanasia.

Deceased Offered Sufficient Information

Our proposed guidelines require that the deceased be offered sufficient information about the decision to end his or her life including, where appropriate, information from qualified medical or other health professionals. Since *Hopp v Lepp*[87] and *Reibl v Hughes*[88], Canadian law has recognized that medical and other health professionals have a duty to offer all information that a reasonable person in the position of the patient would want to know about the recommended treatment, alternatives to this treatment, and the consequences of not undergoing any treatment. The Supreme Court of Canada's reasoning in both decisions was based on autonomy: a person can only make a meaningful choice to undertake or refuse treatment with relevant information about what that treatment involves, including its potential risks. Recognition of the need for an autonomous decision requires that the deceased was offered such information.

Evidence as to whether sufficient information has been offered to the deceased will include evidence about the nature of the information offered to the deceased, such as whether it included relevant information about the diagnosis, prognosis, and treatment options for a person's illness or disability (if any), other care options including palliative care, the nature of possible methods of voluntary euthanasia or assisted suicide and associated risks, and the consequences of alternative courses of action. Further evidence that is relevant to the sufficiency of information offered to the deceased is whether any of that information was misleading or inaccurate, whether the deceased had already gathered some or all of the relevant information on his or her own, and whether the information offered was in a form that the deceased could understand.

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Picard & Gerald Robertson, *Legal Liability of Doctors and Hospitals in Canada*, 4th ed (Toronto: Thomson Carswell, 2007).

[87] [1980] 2 SCR 192, 4 WWR 645.

[88] [1980] 2 SCR 880, 114 DLR (3d) 1.

**Guidelines text**

**Elements of an Autonomous Choice**

The elements of an autonomous choice by the deceased for his or her life to end are:

1. The deceased was capable of making the decision to end his or her life;
2. The decision was made voluntarily by the deceased; and
3. The deceased was offered sufficient information in relation to the decision to end his or her life.

**Direct Evidence in Relation to the Elements of an Autonomous Choice**

Factors that may be relevant to determining whether the deceased's death occurred as a result of an autonomous choice by him or her include:

- Whether the deceased had been assessed recently as having capacity to make the decision to end his or her life by an appropriately qualified medical or other health professional (capacity);
- Whether the deceased needed assistance to make decisions about other aspects of his or her life (capacity);
- Whether there was a clear and unequivocal request from the deceased for voluntary euthanasia or assisted suicide (voluntary);
- Whether the suggestion to consider voluntary euthanasia or assisted suicide came from the deceased or from the suspect or others (voluntary);
- Whether the suspect or others took steps to ensure that the deceased's decision was not brought about by pressure or coercion (voluntary); and
- Whether the suspect or others took steps to ensure that the deceased was offered sufficient information about the decision including, where appropriate, by qualified medical or other health professionals (information).

*Component Four: Confidence Whether Death Occurred as a Result of Autonomous Choice*

The proposed guidelines also include factors that are relevant to a prosecutor's confidence about whether the death that occurred was the result of an autonomous choice by the deceased ("confidence factors"). The role of these factors is different from those mentioned in the previous section, where the goal was to identify matters that could be used as direct evidence in relation to whether the three elements of an autonomous choice discussed above were

satisfied. The factors in this section do not have that same direct probative value and so cannot be used in that way.

Two examples of confidence factors are where the suspect has an interest that conflicts with the interest of the deceased in making an autonomous choice about death (conflict of interest), and where there is a history of violence or abuse towards the deceased by the suspect. These factors are not direct evidence of an absence of autonomy, as it is possible that decisions that occur in the presence of such factors can still be autonomous and therefore not give rise to prosecution. For example, a DPP who was firmly satisfied that a deceased had made an autonomous choice to die, in spite of the existence of potentially negative confidence factors, would be justified under our guidelines in not prosecuting. Nevertheless, the presence of these circumstances can give rise to real doubts that such a choice has been made. This risk is sufficient to justify addressing them in the guidelines.

One of the guiding principles for constructing these guidelines is the importance of public confidence in prosecutorial decision making. If circumstances raising doubt that there was an autonomous choice are specifically addressed, the public can have confidence that prosecutorial discretion is only being exercised to decline to prosecute in clear cases of autonomous decision making.

Also included in this section are confidence factors that are indirectly about autonomy. An example is whether a suspect reported the deceased's death to the police or coroner, and co-operated with the investigation into the death. Such action is not directly about whether the death occurred as a result of an autonomous choice. However, reporting and co-operation by a suspect might suggest that his or her behaviour is more likely to be consistent with the non-prosecution factors in the guidelines than if the suspect concealed his or her involvement. Given that the non-prosecution factors are based on the deceased making an autonomous choice, these factors can still, albeit indirectly, give rise to confidence or doubts as to the nature of any choice made by the deceased.

These confidence factors have two functions in the guidelines. The first is that factors which give rise to doubts about whether the deceased made an autonomous choice for his or her life to end act as triggers for further investigation or scrutiny of the circumstances in which the death occurred. The presence of these confidence factors is a warning that should prompt a prosecutor to review even more closely the direct evidence in relation to the elements of an autonomous choice in the case at hand. We note that confidence

factors can also provide reassurance that the deceased chose to die, but we are not proposing a reduced level of scrutiny in such cases. The second function of confidence factors is that they must be used by prosecutors in their deliberations when weighing the direct evidence of the elements of an autonomous choice set out above. To illustrate, the existence of a troubling conflict of interest is an important part of the context in which prosecutors would assess the available direct evidence about whether the deceased was capable of making a voluntary decision. We now consider the four confidence factors we include in our proposed guidelines.

History of Violence or Abuse

A history of violence or abuse by the suspect towards the deceased gives rise to real concerns about whether the deceased made an autonomous choice for his or her life to end. Such abuse need not be physical in nature and can include emotional or psychological abuse. While it is possible for a decision to end one's life to be made autonomously despite that history, the existence of this type of relationship between the suspect and the deceased casts doubt over this and poses a risk as to whether or not the decision was autonomous.[89] Accordingly, the guidelines identify this factor as one that should trigger very close scrutiny of the circumstances in which the death occurred. A prosecutor should weigh any available evidence as to whether the deceased made an autonomous choice in light of this history. Part of this may include accessing information or advice about the dynamics of such relationships and the impact that any violence or abuse may have had on the deceased's capacity to make his or her own choices.

Settled Decision

A confidence factor which may point the other way is that the deceased's decision appeared to be a settled one (that is, that the deceased is not ambivalent about his or her death). One way this could be demonstrated is through repeated requests by the deceased for his or her life to end. We note that the settled nature of a decision is not an element of an autonomous choice: it is

[89] For a discussion of some of the evidence as to the impact that a history of violence and/or coercion can have autonomy, albeit in the case of domestic violence, see Tamara Kuennen, "Analysing the Impact of Coercion on Domestic Violence Victims: How Much is Too Much?" (2007) 22 Berkeley Journal of Gender, Law & Justice 1. See also Cheryl Hanna, "The Paradox of Progress: Translating Evan Stark's Coercive Control into Legal Doctrine for Abused Women" (2009) 15 Violence Against Women 1458.

not part of the law that governs the refusal of medical treatment discussed above. Nevertheless, if a decision appears to be a settled one, then a prosecutor, and indeed the public, could have greater confidence that the choice was autonomous. However, as noted above, we are not suggesting this should lead to a lower level of scrutiny than that which generally occurs in these cases.

Conflict of Interest

One factor tending to undermine confidence that the deceased's death occurred as a result of an autonomous choice by him or her is that there is an interest on the part of the suspect that conflicts with the interest of the deceased in making that choice. Sometimes the nature of the conflict is such that it tempts the suspect to coerce the deceased or otherwise undermine free choice. Other times the conflict might not be in direct opposition to a deceased's autonomy, but might instead indicate that the suspect was careless or disinterested in ensuring that death was genuinely the deceased's choice. In both instances, however, the existence of a conflict creates the risk that the deceased is not making an autonomous choice: this is what warrants inclusion of conflict of interest as a confidence factor in the guidelines.

There is a range of interests that can give rise to this conflict. One is where a suspect has a financial interest in the deceased's death. The obvious example is where the suspect or a person close to him or her will benefit financially through an inheritance. A financial conflict of interest can also arise not because of the deceased's death, but because a suspect is financially remunerated for providing assistance of some kind. This could arise in relation to an organization that facilitates voluntary euthanasia or assisted suicide for a fee. Another such example is where a medical or other health professional participates in the deceased's death and is remunerated for that. Other conflicts of interest may be non-financial: e.g., a suspect may have reputational interests which may be in conflict with the deceased's autonomous choice. A suspect may also wish to be relieved of the burden of caring for the deceased.

Under our proposed guidelines, the presence of a conflict of interest will trigger a prosecutor to closely scrutinize the circumstances of the deceased's death and to weigh the evidence in relation to the nature of any choice made by the deceased in light of that conflict. The level of this additional scrutiny and deliberation will depend, however, on the nature of the conflict and the

extent to which the suspect's own interests were significant in the decision to end the deceased's life or provide assistance to do so.[90]

The nature of the conflict will determine the extent of additional scrutiny and deliberation required. The issue here is whether the potential for the suspect to benefit is either, firstly, so remote so that it is of no consequence for the suspect, or secondly, if it is not too remote, whether it is insufficient to be a relevant factor in the decision to end, or to assist with ending, the deceased's life. It is this second issue that will be most significant in this context. It is ultimately a matter for the prosecutor to determine, on the facts of the case, how concerned he or she should be by the conflict of interest. To illustrate, an inheritance for a suspect will automatically trigger additional scrutiny and deliberation, but a prosecutor will need to determine the extent to which it could be regarded as a relevant factor in the suspect's decision making process. We consider that very close scrutiny would be called for where the suspect's financial circumstances had recently changed for the worse and this seemed to prompt a renewed interest in assisting the deceased. By contrast, a medical or other health professional who received payment for providing a medical or other health service as part of their usual care for a patient is unlikely to have considered that remuneration a relevant factor in their decision to be involved in the death. More scrutiny will be required, however, if that professional had established a practice devoted exclusively or primarily with assisting people to die, and consequently depended on voluntary euthanasia or assisted suicide for his or her livelihood.[91]

Reporting the Death

The guidelines include as a confidence factor whether or not the suspect reported the death to the police or coroner and co-operated fully with its in-

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[90] This approach has similarities to the "common sense" one outlined in the England and Wales guidelines where a suspect may obtain a benefit from the deceased's death but that this need not be a factor in favour of prosecution if "compassion was the only driving force" for his or her actions. See England and Wales Guidelines, *supra* note 12 at para 44.

[91] We note that earlier in this paper we argued against treating "acting in a professional capacity in and of itself" as a factor tending in favour of prosecution, see England and Wales Guidelines, *supra* note 12. This is not an inconsistency. The fact that a medical or other health professional is involved in voluntary euthanasia or assisted suicide in a professional capacity does not of itself point towards prosecution. However, if that involvement gives rise to a conflict of interest then that must be considered by a prosecutor as a confidence factor.

vestigation. How a suspect behaves in this regard can inform a prosecutor's confidence as to whether a person's death occurred in conformity with the non-prosecution factors in the guidelines which, as noted above, goes indirectly to the confidence a prosecutor can have in relation to whether there was an autonomous choice by the deceased. While there can be other motivations, one reason why a suspect may feel able to report the death to police or coroner is that they will not be prosecuted based on the criteria in the guidelines. By contrast, it could be argued that a suspect whose involvement in a death points towards the factors in favour of prosecution would be more likely to conceal the death or his or her involvement in it, or refuse to participate in a police or coroner's investigation, for fear of the adverse consequences.[92]

Assuming that these arguments are correct, then reporting and co-operation is an appropriate confidence factor for the guidelines. As with other confidence factors, a troubling response warrants additional scrutiny and deliberation whereas a comforting response does not reduce the rigour of a prosecutor's approach, but is relevant to deliberations as to how any evidence in relation to an autonomous choice is weighed.

We also note that including this particular factor has additional systemic benefits for how the guidelines operate above and beyond deliberations in particular cases. Incentivizing disclosure of cases involving voluntary euthanasia and assisted suicide so they may be investigated adds to the public confidence that potential suspects are acting, and will in the future act, in accordance with the guidelines. It also bolsters the public reporting of cases involving the guidelines (proposed below), which again promotes public confidence that the guidelines are functioning appropriately.

**Guidelines text**

**Confidence Whether Death Occurred as a Result of Autonomous Choice**

The presence of factors that *give confidence* that the deceased's death occurred as a result of an autonomous choice by him or her does not reduce the scrutiny that the circumstances of the death receive. Such factors can, howev-

[92] Of course, there could also be other motivations for not reporting the death to police or coroner and co-operating with its investigation. For example, a person whose conduct is otherwise unlikely to attract prosecution may not be aware of the guidelines and so conceal his or her involvement in the death for fear of prosecution.

er, be used in weighing any direct evidence available in relation to whether the elements of an autonomous choice are satisfied. These factors include:

- The deceased's decision for his or her life to end appeared to be a settled one; and
- The suspect reported the death to the police or coroner within a reasonable time and co-operated fully with the investigation.

The presence of factors that *raise doubts* that the deceased's death occurred as a result of an autonomous choice by him or her triggers additional scrutiny of the circumstances of the death. Such factors can also be used in weighing any direct evidence available in relation to whether the elements of an autonomous choice are satisfied. These factors include:

- There is a history of violence or abuse by the suspect towards the deceased;
- There is an interest on the part of the suspect that conflicts with the interest of the deceased in making an autonomous choice about death. In determining the level of additional scrutiny and deliberation that is required, regard must be given to the likelihood of the conflict arising and whether the interest is such as to be a relevant factor in the suspect's decision making; and
- The suspect did not report the death to the police or coroner within a reasonable time or did not co-operate fully with the investigation.

*Component Five: Decision Consented To By the Attorney General*

It was noted above that two of the principles that inform how the guidelines are constructed are:

1. the decision making pursuant to the prosecutorial discretion in this area needs to be of high-quality; and

2. the decision making pursuant to that discretion needs to attract public confidence.

One way in which these goals can be promoted is by requiring that decisions whether or not to prosecute under the guidelines be consented to by the Attorney General. We note that this is consistent with Canadian jurisdictions already having provisions dealing with when the Attorney General's consent is

specifically required either to bring or to discontinue a prosecution.[93] Such an approach is also largely consistent with the position in England and Wales, although the DPP's role in that jurisdiction is given legislative force – section 2(4) of the *Suicide Act*, *1961* (UK)[94] provides that proceedings under that Act may be instituted only with the consent of the DPP. However, there are some important differences between the position there and what is being proposed in these guidelines. First, our proposed guidelines rest the consent requirement with the Attorney General rather than, as is done in England and Wales, with the DPP. We would argue that it is better to have the consent rest at the highest point of public accountability in all jurisdictions (which is the Attorney General even in those few jurisdictions with a statutorily independent DPP).[95] Also, it seems unwise to have the consent on a matter such as this rest at different levels of political superintendence and public accountability in different jurisdictions (and given the different approaches taken in different provinces and territories, it would have to rest with the DPP in some jurisdictions and with the Attorney General or Assistant Attorney General in others). Second, our proposed guidelines are broader than the position in England and Wales in that the DPP's consent is only required if a prosecution is instituted. The DPP is not required by the Act to make decisions where it is proposed that a person not be prosecuted; his or her role is only mandated where there is a decision to prosecute. We understand, however, that the approach taken to date is for the DPP to be involved in all decisions (including those not to prosecute),[96] which is consistent with our proposed approach.

Another key difference relates to the wider function of the consent provision in England and Wales. The House of Lords in *Purdy* identified that the "basic reason" for the relevant subsection is to prevent the risk of prosecutions in "inappropriate circumstances."[97] A significant motivation for imposing a legislative requirement for DPP consent to prosecutions is to avoid

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[93] For example, *Criminal Code*, *supra* note 2 s 477.2(1) (offences committed in or on territorial sea of Canada) and s 4.1 (offence in relation to sexual offences against children committed outside Canada) require the consent of the Attorney General of Canada. See e.g. Ontario, Ministry of Attorney General, "Attorney General's Consents" in "Crown Policy Manual" (Toronto: MAG, 21 March 2005), online: <www.attorneygeneral.jus.gov.on.ca/english/crim/cpm/2005/AGConsents.pdf>.

[94] England and Wales Guidelines, *supra* note 12; *Suicide Act*, *1961* (UK), c 60, s 2(1).

[95] Nova Scotia, Québec, and federal.

[96] Keir Starmer Transcript, *supra* note 40.

[97] *Purdy*, *supra* note 29 at 392 (Lord Hope of Craighead).

vexatious or inappropriate private prosecutions.[98] Our proposed guidelines do not directly address this concern as they only purport to guide the exercise of prosecutorial discretion by the State and cannot in and of themselves, unlike a legislative requirement for consent, prevent inappropriate private prosecutions.

Nevertheless, despite these differences, some of the rationales for section 2(4) of the *Suicide Act 1961* (UK) are relevant to the proposed fifth component of our guidelines. In particular, we note that the House of Lords in *Purdy* pointed to reasons underpinning the consent requirement as including "to secure consistency of practice, … to enable account to be taken of mitigating factors and to provide some central control of the use of the criminal law where it has to intrude into areas which are particularly sensitive or controversial."[99] We agree and consider that requiring the Attorney General to consent to all decisions whether to prosecute or not under these guidelines will provide central control and lead to greater consistency and predictability in decision making. These factors would also promote public confidence in decisions made pursuant to the guidelines.

**Guidelines text**

**Decision Consented to by the Attorney General**

All decisions whether or not to prosecute cases involving voluntary euthanasia and assisted suicide pursuant to these guidelines must be consented to by the Attorney General.

*Component Six: Public Reporting of Decision Making*

Another way in which high-quality decision making that attracts public confidence can be promoted is through giving reasons for decisions and making them publicly available. We propose this be done where possible in relation to individual decisions not to prosecute, but also through the collection and publication of information about how the guidelines are operating at a systemic level.

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[98] For a wider discussion of the importance of the right to bring a private prosecution, and the corresponding justifications advanced for requiring DPP or other consents to prosecution, see UK, Law Commission, *Consents to Prosecution* (Law Com No 255) (London: Her Majesty's Stationery Office, 1998) at paras 2-3. See also *Purdy*, *supra* note 29 at 392 (Lord Hope of Craighead).

[99] *Purdy, supra* note 29 at 392 (Lord Hope of Craighead); Williams, *supra* note 38 at 184-85.

Reasons for Decisions

Subject to any contrary legal obligations prohibiting such a course, prosecutors are able to give reasons for their prosecutorial decisions and make them publicly available.[100] In British Columbia, a commission of inquiry made the following recommendation, which has been adopted by the Crown:

> Where a decision not to prosecute has been made, and the public, a victim or other significantly interested person is aware of the police investigation, it is in the public interest that the public, victim or other significantly interested person be given adequate reasons for the non-prosecution, by either the police or Crown Counsel.[101]

In Prince Edward Island, prosecutors are advised to keep a record of the reasons for a decision not to prosecute, and to be conscious of the need in appropriate cases to explain the reasons for the decision to affected parties.[102]

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[100] Indeed in Canada, the common law imposes a duty on administrative decision makers to provide reasons in certain circumstances "where the decision has important significance for the individual, when there is a statutory right of appeal, or in other circumstances" (*Baker v Canada* (*Minister of Citizenship and Immigration*), [1999] 2 SCR 817 at para 48, 174 DLR (4th)).

[101] British Columbia, *Discretion to Prosecute Inquiry: Commissioner's Report* ("The Owen Inquiry") (Victoria: Discretion to Prosecute Inquiry, 1990) at 110, 118, Recommendation 8(2). Section 15(4) of the *Freedom of Information and Protection of Privacy Act*, RSBC 1996, c 165 facilitates compliance with this recommendation:

> 15(4) The head of a public body must not refuse, after a police investigation is completed, to disclose under this section the reasons for a decision not to prosecute
>
> (a) to a person who knew of and was significantly interested in the investigation, including a victim or a relative or friend of a victim, or
>
> (b) to any other member of the public, if the fact of the investigation was made public.

See also British Columbia, Ministry of Attorney General, "Disclosure of Information to Parties other than the Accused" in "Crown Counsel Policy Manual" by the Criminal Justice Branch (Victoria: MAG, 18 November 2005), online: <www.ag.gov.bc.ca/prosecution-service/policy-man/pdf/DIS1.1-DisclosureOfInformationtToParties-18Nov2005.pdf>.

[102] Justice and Public Safety, "Guide Book of Policies and Procedures for the Conduct of Criminal Prosecutions in Prince Edward Island" by the Crown Attorneys'

According to the guidelines: "this approach will encourage reasoned decision making."[103] The Newfoundland guidelines explicitly recognize that public confidence in the administration of justice may require the giving of reasons where appropriate.[104] Several other provinces have guidelines dealing with media interaction that acknowledge that public confidence is enhanced by the timely provision of accurate information to the public.[105] In Alberta, however, prosecutors are instructed to refuse the release of information on any file where a decision has been made not to prosecute.[106]

To advance the guiding principles of high-quality decision making and public confidence, the guidelines should require that where possible, reasons for decisions be given in these cases and made publicly available. We note, however, that this aspect of the guidelines applies only to decisions *not* to prosecute, and *not* to decisions favouring a prosecution. Aside from concerns about prejudicing either the Crown's ability to prosecute or the accused's right to a fair trial, a decision to prosecute means the Crown's case is sub-

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Office (Charlottetown: JPS, November 2009) at 5-7, online: <www.gov.pe.ca/photos/original/jps_crownconduc.pdf>.

[103] *Ibid*.

[104] Office of the Director of Public Prosecutions, "Communications with the Media" in "Guidebook of Policies and Procedures for the Conduct of Criminal Prosecutions in Newfoundland and Labrador" (St. John's: ODPP, October 2007) at 10-1, online: <www.justice.gov.nl.ca/just/prosecutions/pp_guide_book.pdf>.

[105] See e.g. Nova Scotia, Public Prosecution Service, "Media Inquiries and Public Statements" in "Crown Attorney Manual" (Halifax: PPS, 4 July 2011), online: <www.gov.ns.ca/pps/publications/ca_manual/AdministrativePolicies/MediaRelations.pdf>; Ontario, Ministry of Attorney General, "Media Contact by Crown Counsel by the Criminal in "Crown Policy Manual" by the Law Policy Branch (Toronto, MAG, 21 March 2005), online: <www.attorneygeneral.jus.gov.on.ca/english/crim/cpm/2005/MediaContactByCrown.pdf>; Manitoba, Department of Justice, "Communication with the News Media" in "Prosecution Policies" by the Manitoba Prosecution Service (Winnipeg, DOJ, November 2008), online: <www.gov.mb.ca/justice/prosecutions/ policy/index.html>.

[106] Section 20(6) of the *Freedom of Information and Protection of Privacy Act*, RSA 2000, c F-25 provides that the head of a public body may disclose reasons for a decision not to prosecute to the public. However, the Minister of Justice and Attorney General instructs prosecutors to rely on s 20(1)(g), which permits the head of a public body to refuse to disclose information that could reasonably be expected to reveal any information relating to or used in the exercise of prosecutorial discretion. Although this exemption is found in the legislation of several provinces, only prosecutors in Alberta have been explicitly advised to consistently rely on it to deny information regarding decisions not to prosecute.

jected to the public rigour of the criminal justice system, and this is sufficient to address the guiding principles of high-quality decision making and public confidence identified above.

There are a number of benefits in publishing reasons for decisions. One is that the discipline of producing written reasons assists a decision maker in his or her deliberations and ensures the reasoning is subjected to the rigour of justification, thereby promoting high-quality decision making.[107] Requiring justification of a conclusion to the public also ensures accountability and transparency in decision making, which in turn supports public confidence.[108] A third benefit is that awareness of how these decisions are made promotes predictability and consistency in decision making, and certainty in the law.[109] This is of advantage for prosecutors and the Attorneys General, as this body of knowledge would enhance their deliberations in relation to these decisions. It also assists members of the public who will not only know the general criteria for prosecution decisions, but also how those criteria are being applied in practice. This will enable people to regulate their own conduct so as to ensure, if possible, that it is not in the public interest for them to be prosecuted.

While these benefits are applicable generally to the exercise of prosecutorial discretion, we consider the case for published reasons for decisions is particularly compelling in relation to voluntary euthanasia and assisted suicide. As the experience in England and Wales has demonstrated, prosecutorial discretion in this area can give rise to a high level of public interest and concern about how it may be exercised.[110] It is therefore appropriate that the public be able to scrutinize these decisions, and be reassured they are being made in accordance with the guidelines. These concerns have prompted the DPP in England and Wales to make publicly available the reasons for his decisions in relation to the assisted suicide guidelines where the information about the case is already in the public domain.[111] Accordingly, although the majority of guidelines already address in a generic way the issue of reasons

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[107] Jones & de Villars, *supra* note 72 at 372-73; Blake, *supra* note 72 at 92.

[108] Jones & de Villars, *supra* note 72; Blake, *supra* note 72.

[109] Jones & de Villars, *supra* note 72; Blake, *supra* note 72.

[110] See England and Wales Interim Policy Summary, *supra* note 33.

[111] Keir Starmer Transcript, *supra* note 40 at 4. See e.g. The Crown Prosecution Service, "The Suicide of Mr Raymond Cutkelvin: Decision on Prosecution" (25 June 2010), online: CPS <www.cps.gov.uk/news/articles/the_suicide_of_ mr_ raymond_cutkelvin_decision_on_prosecution/>.

for decisions, we consider it should be specifically dealt with in these guidelines, and that reasons for decisions should be provided and made public wherever possible.

We do recognize, however, that the context of prosecutorial decision making means that there are constraints that may limit or preclude giving full reasons or making reasons publicly available. Attorneys General are subject to various legislative privacy obligations which, absent a relevant exception, prohibit publication of certain information.[112] Some or all of these obligations may not apply, however, in relation to information that is already in the public domain (for example, where information is discussed in open court at a committal hearing and the prosecution is later discontinued). Another relevant consideration is whether the production and publication of reasons would prejudice the prosecution of a co-offender or an ongoing investigation. Other public interest considerations which may weigh against giving reasons are if doing so would significantly prejudice the administration of justice or cause serious harm to witnesses or the suspect. Accordingly, it will not always be possible to produce and publish reasons for decisions. Nevertheless, we consider the publication of reasons should be the presumed norm and where publication of reasons is not possible, consideration should also be given to whether it is possible to publish reasons of some kind that do not prejudice those other obligations. For example, it might be possible to make reasons for a decision available in a de-identified form, or for the reasons not to refer to particular information that should not be disclosed.

Systemic Data Reporting in Annual Report

Another way in which high-quality decision making that attracts public confidence can be promoted is to monitor how the guidelines are working at a systemic level. This permits a level of scrutiny of global trends to ensure that the guidelines are leading to appropriate outcomes. Such an approach is generally a feature of voluntary euthanasia and assisted suicide laws which establish or empower a Commission or other body to oversee the administra-

[112] See e.g. *Privacy Act*, RSC, 1985, c P-21; *Freedom of Information and Protection of Privacy Act*, SNS 1993, c 5; *Freedom of Information and Protection of Privacy Act*, SM 1997, c 50, CCSM c F175; *Freedom of Information and Protection of Privacy Act*, RSO 1990, c F-31; *Youth Criminal Justice Act*, SC 2002, c 1.

tion of the legislation.[113] Again, this information should be made available for public scrutiny.

The reporting of systemic data (which can be done in a de-identified form)[114] will be valuable for determining whether the terms of the guidelines themselves are appropriate or not. It will also permit scrutiny of how the guidelines are being applied in practice over a period of time. This sort of scrutiny ensures that decision making is of a high-quality and enables problems to be identified and addressed.[115] It also can provide a measure of public confidence in that the community knows how the guidelines are being used and what the outcomes are. This data can include decisions to prosecute as concerns about prejudicing the prosecution identified in relation to reasons for decisions need not arise at this systemic de-identified level of reporting, or if they do, the data can be included at a later stage once all proceedings have been concluded.

The nature of the systemic data we consider should be captured includes:

- demographic data for the deceased such as gender, age, ethnic background, health status, disabilities (if any), income level and educational level;

- the deceased's underlying illness (if any);

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[113] See the summary description of the various oversight mechanisms in the Netherlands, Belgium, Luxembourg, Oregon and Washington State in RSC Panel, *supra* note 4. The need for the collection and reporting of data was also recognized by the RSC Panel, *ibid* at 102. The collection and publication of data to improve the administration of criminal law processes has also been suggested in relation to 'death penalty' cases in the United States. See James Liebman, "The Overproduction of Death" (2000) 100 Colum L Rev 2030.

[114] Although there will likely be few cases, other jurisdictions with smaller or similar populations to a number of Canadian provinces (e.g. Oregon is very close to or smaller than Québec, Ontario, BC, and Alberta) have been able to publish systemic data without revealing identifiable information. That said, reporting without risking identification may be difficult in the smaller jurisdictions. This point could support the pooling of information and reporting at a regional or national level (Canada's population is substantially larger than Oregon and the Netherlands).

[115] See for example experiences with respect to "life ending acts without explicit request of the patient" and reporting rates in the Netherlands and Belgium as discussed in Rietjens et al, *supra* note 74 and Chambaere et al, *supra* note 79.

- whether the deceased had access to palliative care;
- whether the deceased had private health insurance;
- the relationship between the suspect and the deceased;
- whether the case involved voluntary euthanasia or assisted suicide;
- the number of decisions reached to prosecute or not prosecute; and
- the number of convictions that occurred in those cases where the decision was to prosecute.

To achieve an understanding of the trends that might be emerging from the use of the guidelines, the data collected with respect to the first six elements in this list needs to be correlated with that collected with respect to the final two.

**Guidelines text**

**Public Reporting of Decision Making**

Subject to any contrary legal obligation, the Attorney General will produce and publish reasons for a decision to not prosecute a case involving voluntary euthanasia and assisted suicide. Before concluding that the production and publication of reasons for a decision is not possible, consideration will be given to whether the reasons could be published in a more limited form.

The Attorney General will publish in an Annual Report systemic data about what decisions are being made and how they are being made in accordance with these guidelines.

**Conclusion**

The purpose of this article was to construct offence-specific guidelines for how prosecutorial discretion should be exercised in cases of voluntary euthanasia and assisted suicide. The guidelines are meant to be consistent with the arguments made and conclusions drawn in the RSC Panel Report and to translate into practice the Panel's recommendation with respect to prosecutorial charging guidelines. In undertaking this task, we were guided by the well-established principles of respect for autonomy, the need for high-quality

prosecutorial decision making, and the importance of public confidence in that decision making. From these principles, we derived six components of a set of guidelines: an additional public interest factor (autonomy); elements of an autonomous choice; direct evidence of an autonomous choice; confidence whether death occurred as a result of autonomous choice; decision consented to by the Attorney General; and public reporting of decision making. It is our hope that the preceding discussion and proposed guidelines can make a useful contribution to Canadian provinces and territories as they wrestle with the issue of how to respond to calls for the development of permissive regimes with respect to voluntary euthanasia and assisted suicide through the adoption of guidelines for the exercise of prosecutorial discretion.

## Appendix I: Proposed Prosecutorial Guidelines for Voluntary Euthanasia and Assisted Suicide (Consistent with RSC Panel Approach)

### Autonomous Choice: An Additional Public Interest Factor Specific to these Offences

An additional public interest factor that tends against prosecution is that the deceased's death occurred as a result of an autonomous choice made by the deceased for his or her life to end.

An additional public interest factor that tends in favour of prosecution is that the deceased's death did not occur as a result of an autonomous choice made by the deceased for his or her life to end.

### Elements of an Autonomous Choice

The elements of an autonomous choice by the deceased for his or her life to end are:

1. The deceased was capable of making the decision to end his or her life;

2. The decision was made voluntarily by the deceased; and

3. The deceased was offered sufficient information in relation to the decision to end his or her life.

### Direct Evidence in Relation to the Elements of an Autonomous Choice

Factors that may be relevant to determining whether the deceased's death occurred as a result of an autonomous choice by him or her include:

- Whether the deceased had been assessed recently as having capacity to make the decision to end his or her life by an appropriately qualified medical or other health professional (capacity);

- Whether the deceased needed assistance to make decisions about other aspects of his or her life (capacity);

- Whether there was a clear and unequivocal request from the deceased for voluntary euthanasia or assisted suicide (voluntary);

- Whether the suggestion to consider voluntary euthanasia or assisted suicide came from the deceased or from the suspect or others (voluntary);

- Whether the suspect or others took steps to ensure that the deceased's decision was not brought about by pressure or coercion (voluntary); and

- Whether the suspect or others took steps to ensure that the deceased was offered sufficient and accurate information about the decision including, where appropriate, by qualified medical or other health professionals (information).

**Confidence Whether Death Occurred as a Result of Autonomous Choice**

The presence of factors that *give confidence* that the deceased's death occurred as a result of an autonomous choice by him or her does not reduce the scrutiny that the circumstances of the death receive. Such factors can, however, be used in weighing any direct evidence available in relation to whether the elements of an autonomous choice are satisfied. These factors include:

- The deceased's decision for his or her life to end appeared to be a settled one; and

- The suspect reported the death to the police or coroner within a reasonable time and co-operated fully with the investigation.

The presence of factors that *raise doubts* that the deceased's death occurred as a result of an autonomous choice by him or her triggers additional scrutiny of the circumstances of the death. Such factors can also be used in weighing any direct evidence available in relation to whether the elements of an autonomous choice are satisfied. These factors include:

- There is a history of violence or abuse by the suspect towards the deceased;

- There is an interest on the part of the suspect that conflicts with the interest of the deceased in making an autonomous choice about death. In determining the level of additional scrutiny and deliberation that is required, regard must be had to the likelihood of the conflict arising and whether the interest is such as to be a relevant factor in the suspect's decision making; and

- The suspect did not report the death to the police or coroner within a reasonable time or did not co-operate fully with the investigation.

**Decision Consented to by the Attorney General**

All decisions whether or not to prosecute cases involving voluntary euthanasia and assisted suicide pursuant to these guidelines must be consented to by the Attorney General.

**Public Reporting of Decision Making**

Subject to any contrary legal obligation, the Attorney General will produce and publish reasons for a decision to not prosecute a case involving voluntary euthanasia and assisted suicide. Before concluding that the production and publication of reasons for a decision is not possible, consideration will be given to whether the reasons could be published in a more limited form.

The Attorney General will publish in an Annual Report systemic data about what decisions are being made and how they are being made in accordance with these guidelines.

## Appendix II: Alternative Prosecutorial Guidelines for Voluntary Euthanasia and Assisted Suicide (Our Proposed Guidelines with the Addition of Protection of the Vulnerable Public Interest Factors Consistent with the Carter Approach)

### Autonomous Choice: An Additional Public Interest Factor Specific to These Offences

An additional public interest factor that tends against prosecution is that the deceased's death occurred as a result of an autonomous choice made by the deceased for his or her life to end.

An additional public interest factor that tends in favour of prosecution is that the deceased's death did not occur as a result of an autonomous choice made by the deceased for his or her life to end.

### Elements of an Autonomous Choice

The elements of an autonomous choice by the deceased for his or her life to end are:

1. The deceased was capable of making the decision to end his or her life;

2. The decision was made voluntarily by the deceased; and

3. The deceased was offered sufficient information in relation to the decision to end his or her life.

### Direct Evidence In Relation to the Elements of an Autonomous Choice

Factors that may be relevant to determining whether the deceased's death occurred as a result of an autonomous choice by him or her include:

- Whether the deceased had been assessed recently as having capacity to make the decision to end his or her life by an appropriately qualified medical or other health professional (capacity);

- Whether the deceased needed assistance to make decisions about other aspects of his or her life (capacity);

- Whether there was a clear and unequivocal request from the deceased for voluntary euthanasia or assisted suicide (voluntary);

- Whether the suggestion to consider voluntary euthanasia or assisted suicide came from the deceased or from the suspect or others (voluntary);

- Whether the suspect or others took steps to ensure that the deceased's decision was not brought about by pressure or coercion (voluntary); and

- Whether the suspect or others took steps to ensure that the deceased was offered sufficient and accurate information about the decision including, where appropriate, by qualified medical or other health professionals (information).

**Confidence Whether Death Occurred as a Result of Autonomous Choice**

The presence of factors that *give confidence* that the deceased's death occurred as a result of an autonomous choice by him or her does not reduce the scrutiny that the circumstances of the death receive. Such factors can, however, be used in weighing any direct evidence available in relation to whether the elements of an autonomous choice are satisfied. These factors include:

- The deceased's decision for his or her life to end appeared to be a settled one; and

- The suspect reported the death to the police or coroner within a reasonable time and co-operated fully with the investigation.

The presence of factors that *raise doubts* that the deceased's death occurred as a result of an autonomous choice by him or her triggers additional scrutiny of the circumstances of the death. Such factors can also be used in weighing any direct evidence available in relation to whether the elements of an autonomous choice are satisfied. These factors include:

- There is a history of violence or abuse by the suspect towards the deceased;

- There is an interest on the part of the suspect that conflicts with the interest of the deceased in making an autonomous choice about death. In determining the level of additional scrutiny and deliberation that is required, regard must be had to the likelihood of the conflict arising and whether the interest is such as to be a relevant factor in the suspect's decision making; and

- The suspect did not report the death to the police or coroner within a reasonable time or did not co-operate fully with the investigation.

**Protection of the Vulnerable: A Further Additional Public Interest Factor Specific to These Offences**

Factors that tend in favour of prosecution include:

- the assistance was not provided by a medical practitioner in the context of a physician-patient relationship; and

- the assistance was provided to the deceased who:

    - was not materially physically disabled or soon to become so;

    - had not been diagnosed by a medical practitioner as having a serious illness, disease or disability (including disability arising from traumatic injury);

    - was not in a state of advanced weakening capacities with no chance of improvement;

    - did not have an illness that was without remedy as determined by reference to treatment options acceptable to him or her; or

    - did not have an illness causing enduring physical or psychological suffering that was intolerable to him or her and could not be alleviated by any medical treatment acceptable to him or her.

**Decision Consented To by the Attorney General**

All decisions whether or not to prosecute cases involving voluntary euthanasia and assisted suicide pursuant to these guidelines must be consented to by the Attorney General.

**Public Reporting of Decision Making**

Subject to any contrary legal obligation, the Attorney General will produce and publish reasons for a decision to not prosecute a case involving voluntary euthanasia and assisted suicide. Before concluding that the production and publication of reasons for a decision is not possible, consideration will be given to whether the reasons could be published in a more limited form.

The Attorney General will publish in an Annual Report systemic data about what decisions are being made and how they are being made in accordance with these guidelines.

## Appendix III: Alternative Prosecutorial Guidelines for Voluntary Euthanasia and Assisted Suicide (Our Proposed Guidelines with the Addition of Allowing for Advance Directives as Well as Protection of the Vulnerable Public Interest Factors Consistent With the Québec Committee Approach)

### Autonomous Choice: An Additional Public Interest Factor Specific to These Offences

An additional public interest factor that tends against prosecution is that the deceased's death occurred as a result of an autonomous choice made by the deceased for his or her life to end.

An additional public interest factor that tends in favour of prosecution is that the deceased's death did not occur as a result of an autonomous choice made by the deceased for his or her life to end.

### Elements of an Autonomous Choice

The elements of an autonomous choice by the deceased for his or her life to end are:

1. The deceased was capable of making the decision to end his or her life;

2. The decision was made voluntarily by the deceased; and

3. The deceased was offered sufficient information in relation to the decision to end his or her life.

### Direct Evidence In Relation to the Elements of an Autonomous Choice

Factors that may be relevant to determining whether the deceased's death occurred as a result of an autonomous choice by him or her include:

- Whether the deceased had been assessed recently as having capacity to make the decision to end his or her life by an appropriately qualified medical or other health professional (capacity);

- Whether the deceased needed assistance to make decisions about other aspects of his or her life (capacity);

- Whether there was a clear and unequivocal request from the deceased for voluntary euthanasia or assisted suicide (voluntary);

- Whether the suggestion to consider voluntary euthanasia or assisted suicide came from the deceased or from the suspect or others (voluntary);

- Whether the suspect or others took steps to ensure that the deceased's decision was not brought about by pressure or coercion (voluntary); and

- Whether the suspect or others took steps to ensure that the deceased was offered sufficient and accurate information about the decision including, where appropriate, by qualified medical or other health professionals (information).

**Confidence Whether Death Occurred as a Result of Autonomous Choice**

The presence of factors that *give confidence* that the deceased's death occurred as a result of an autonomous choice by him or her does not reduce the scrutiny that the circumstances of the death receive. Such factors can, however, be used in weighing any direct evidence available in relation to whether the elements of an autonomous choice are satisfied. These factors include:

- The deceased's decision for his or her life to end appeared to be a settled one; and

- The suspect reported the death to the police or coroner within a reasonable time and co-operated fully with the investigation.

The presence of factors that *raise doubts* that the deceased's death occurred as a result of an autonomous choice by him or her triggers additional scrutiny of the circumstances of the death. Such factors can also be used in weighing any direct evidence available in relation to whether the elements of an autonomous choice are satisfied. These factors include:

- There is a history of violence or abuse by the suspect towards the deceased;

- There is an interest on the part of the suspect that conflicts with the interest of the deceased in making an autonomous choice about death. In determining the level of additional scrutiny and

deliberation that is required, regard must be had to the likelihood of the conflict arising and whether the interest is such as to be a relevant factor in the suspect's decision making; and

- The suspect did not report the death to the police or coroner within a reasonable time or did not co-operate fully with the investigation.

**Advance Directives**

Despite the foregoing, the element of an autonomous choice is not violated in the context of an advance directive for medical aid in dying where:

- the deceased was irreversibly unconscious, based on scientific knowledge;
- the advance directive:
    - was given in a free and informed manner;
    - was legally binding; and
    - took the form of a notarized act or an instrument signed by two witnesses, including a commissioner of oaths; and
- the assisting physician:
    - consulted another physician to confirm the irreversible nature of the unconsciousness; and
    - the physician consulted was independent of the deceased and the assisting physician.

**Protection of the Vulnerable: A Further Additional Public Interest Factor Specific to These Offences**

Factors that tend in favour of prosecution include:

- the assistance was not provided by a medical practitioner;

- the medical practitioner providing assistance did not consult with another physician on whether the request met the protection of the vulnerable public interest factor;

- the physician consulted was not independent of the deceased and the assisting physician;

- the assisting physician did not complete a formal declaration of medical aid in dying;

- the assistance was provided to an individual who:

    - was not a resident of Québec;

    - was not suffering from a serious, incurable disease;

    - was not in an advanced state of weakening capacities, with no chance of improvement; or

    - did not have constant and unbearable physical or psychological suffering that could not be eased under conditions he or she deemed tolerable;

- the deceased's request was not:

    - made in writing by way of a signed form; or

    - repeated within a reasonable period of time, depending on the type of disease.

**Decision Consented to by the Attorney General**

All decisions whether or not to prosecute cases involving voluntary euthanasia and assisted suicide pursuant to these guidelines must be consented to by the Attorney General.

**Public Reporting of Decision Making**

Subject to any contrary legal obligation, the Attorney General will produce and publish reasons for a decision to not prosecute a case involving voluntary euthanasia and assisted suicide. Before concluding that the production and publication of reasons for a decision is not possible, consideration

will be given to whether the reasons could be published in a more limited form.

The Attorney General will publish in an Annual Report systemic data about what decisions are being made and how they are being made in accordance with these guidelines.