Neutral Citation Number: [2018] EWCA Civ 1431

Case No: C1/2017/3068

IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
Sales LJ, Whipple and Garnham JJ
[2017] EWHC 2447 (Admin)

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 27/06/2018

Before :

THE MASTER OF THE ROLLS
THE PRESIDENT OF THE QUEEN'S BENCH DIVISION
and
LADY JUSTICE KING

- -

Between :

R (on the application of CONWAY)	**Appellant/ Claimant**
- and -	
THE SECRETARY OF STATE FOR JUSTICE	**Respondent/ Defendant**
- and -	
HUMANISTS UK (1) **NOT DEAD YET (UK) (2)** **CNK ALLIANCE LTD (3)**	**Interveners**

- -
- -

Nathalie Lieven QC, **Alex Ruck Keene** and **Annabel Lee** (instructed by **Irwin Mitchell LLP**) for the **Appellant**
James Eadie QC, **James Strachan QC** and **Benjamin Tankel** (instructed by **the Government Legal Department**) for the **Respondent**
Caoilfhionn Gallagher QC and **Graeme Hall** (instructed by **Hodge Jones and Allen LLP**) for the **First Intervener**
Catherine Casserley (instructed by **Fry Law**) for the **Second Intervener**
David Lawson (instructed by **Barlow Robbins LLP**) for the **Third Intervener**

Hearing dates : 1, 2 and 3 May 2018

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Approved Judgment

Sir Terence Etherton MR, Sir Brian Leveson P and Lady Justice King :

1. This is an appeal from the order dated 5 October 2017 of the Divisional Court (Sales LJ, Whipple and Garnham JJ) dismissing the claim of the appellant, Mr Noel Conway ("Mr Conway"), for a declaration under section 4 of the Human Rights Act 1998 ("the HRA") in respect of section 2(1) of the Suicide Act 1961 ("the 1961 Act"), which imposes a blanket ban on assisted suicide. Mr Conway contends that section 2(1) constitutes a disproportionate interference with his right to respect for his private life under Article 8(1) of the European Convention for the Protection of Human Rights and Fundamental Freedoms ("the Convention").

The Factual Background

2. Mr Conway is a 68-year-old man who, in November 2014, was diagnosed with a form of motor neurone disease ("MND"). Mr Conway's condition was summarised by the Divisional Court's judgment as follows (at [5]):

> "MND is a neurological disease which attacks the nerve cells responsible for controlling voluntary muscle movement. The nerve cells degenerate and die and stop sending messages to the muscles. The muscles gradually weaken and waste away. Eventually, the brain's ability to start and control voluntary movement is lost. Mr Conway has to use a wheelchair and requires ever increasing levels of assistance with daily life, eating and bodily functions. The muscles which allow Mr Conway to breathe are also wasting away. He increasingly finds it difficult to breathe without mechanical assistance in the form of non-invasive ventilation ("NIV"), which he requires for an increasing number of hours each day. The average life expectation of a person with MND is between two and five years. …"

3. We were told that, by the time of the hearing before us, his condition had deteriorated to the extent that he required NIV for approximately 23 hours each day. We express our deep sympathy with Mr Conway's circumstances and our profound respect for the dignified and resolute way in which he has been coping with what is a terrible disease.

4. When Mr Conway has a prognosis of six months or less to live, he wishes to have the option of taking action to end his life peacefully and with dignity, with the assistance of a medical professional, at a time of his choosing, whilst remaining in control of the final act that may be required to bring about his death. In his own words:

> "I would like to be able to seek assistance from a medical professional so that I may be prescribed medication which I can self-ingest to end my life successfully, if I wish to do so. If I am unable to take the medication by drinking a prescribed medication, I would also be prepared to receive medication in a different format, by activating a switch for example. I do not believe that unsupervised alternative methods of suicide are humane or acceptable and would be additionally distressing for my loved ones.

> …
>
> I do not wish to get to a stage where my quality of life is so limited, in the last six months of life, that I am no longer able to find any enjoyment in it. This disease is a relentless and merciless process of progressive deterioration. At some point, my breathing will stop altogether or I will become so helpless that I will be effectively entombed in my own body. I would not like to live like this. I would find it a totally undignified state for me to live in. I find the prospect of this state for me to live quite unacceptable and I wish to end my life when I feel it is the right moment to do so, in a way that is swift and dignified. …"

5. It is the law which prevents him from obtaining this assistance with which this appeal is concerned and to which we now turn.

The Legal and Parliamentary Background

Section 2(1) of the Suicide Act 1961

6. Section 2(1) of the 1961 Act prohibits the assistance which Mr Conway desires. By section 1 of the 1961 Act Parliament abolished the rule of law under which it was a crime for a person to commit suicide. Parliament decided, however, to maintain the criminal prohibition of acts capable of providing encouragement or assistance for a person to commit suicide. It did so by enacting section 2(1) of the 1961 Act. Section 2(1), as amended by section 59(2) of the Coroners and Justice Act 2009, as follows:

> "(1) A person ("D") commits an offence if—
>
> (a) D does an act capable of encouraging or assisting the suicide or attempted suicide of another person, and
>
> (b) D's act was intended to encourage or assist suicide or an attempt at suicide."

7. It is, therefore, in respect of section 2(1) that Mr Conway seeks a declaration of incompatibility under section 4 of the HRA, on the basis that it is a disproportionate interference with his right to respect for his private life under Article 8 of the Convention ("Article 8").

8. Since its enactment, the criminal offence in section 2(1), as well as its compatibility with Convention rights, has been the subject of much debate in Parliament and in the courts.

Article 8

9. Article 8 provides as follows:

> "Article 8: Right to respect for private and family life

> (1) Everyone has the right to respect for his private and family life, his home and his correspondence.
>
> (2) There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others."

Early parliamentary engagement with section 2 and questions of assisted suicide

10. In describing Parliament's engagement with the relevant issues in this part of the judgment, we gratefully take much of the detail from the Divisional Court's judgment below, which in turn was taken from the detailed grounds of the Secretary of State ("the SoS") for resisting the claim.

11. The Parliamentary documentation provided to us commences with the 1994 Report of the House of Lords Select Committee on Medical Ethics (HL Paper 21-I, 1994). The Committee concluded in that report that "as far as assisted suicide is concerned" they saw "no reason to recommend any change in the law" (at paragraph 26), primarily on the basis that "the message which society sends to vulnerable and disadvantaged people … should not, however, obliquely, encourage them to seek death, but should assure them of our care and support in life" (at paragraph 239). The Government in its response agreed, on the grounds that a change in the law "would be open to abuse and put the lives of the weak and vulnerable at risk" (1994 Cm 2553, p.5).

The Pretty case

12. That was followed by the House of Lords decision in *R (Pretty) v Director of Public Prosecutions* [2001] UKHL 61, [2002] 1 AC 800 ("*Pretty*"), which was the first major case concerning the impact of the section 2(1) ban upon the human rights of those individuals who wished to seek assistance in bringing about their own death. The claimant, Diane Pretty, suffered from MND. She was mentally alert and wished to control the time and manner of her dying but her physical disabilities prevented her from ending her own life without assistance. The House of Lords accepted (at [1]) that she faced "the prospect of a humiliating and distressing death". Mrs Pretty wished her husband to assist her and he had agreed, provided that the Director of Public Prosecutions ("the DPP") undertook not to prosecute him. Although the court was not provided with any information as to how it was proposed that her husband would assist her suicide, nor any medical evidence showing what Mrs Pretty herself could do to carry out her wish, it was emphasised by the House of Lords (at [44]) that the final act of suicide would be carried out by her. Mrs Pretty sought an assurance from the DPP that her husband would not be prosecuted if he assisted her to commit suicide and she sought additional relief, including a declaration under section 4 of the HRA that section 2 of the 1961 Act was incompatible with her Article 8(1) rights.

13. The House of Lords unanimously dismissed her claim, holding that the DPP had no power to undertake that a crime yet to be committed should be immune from prosecution and also that section 2 of the 1961 Act was not incompatible with her

Article 8(1) rights. The House of Lords reached their conclusion on the basis that Mrs Pretty's rights under Article 8(1) were not engaged (see [26] (Lord Bingham); [61] (Lord Steyn); [99]-[101] (Lord Hope); [112] (Lord Hobhouse) and [124] (Lord Scott)). The House of Lords went on to hold that, even if her rights had been engaged, any interference with them by reason of section 2 was both proportionate and justified under Article 8(2), in particular due to the need to protect the weak and vulnerable in society and to prevent abuse ([26]-[30] (Lord Bingham); [62] (Lord Steyn); [102] (Lord Hope); [112] (Lord Hobhouse); [124] (Lord Scott)). This was the case despite the fact that, as far as Mrs Pretty herself was concerned, she was mentally alert, possessed capacity, had made this decision freely and was not herself a member of the category of vulnerable people in relation to whom section 2 was said to operate as a protection. The House of Lords, therefore, dismissed her appeal and declined to issue a declaration of incompatibility.

14. Subsequently, in *Pretty v United Kingdom* (2002) 35 EHRR 1, Mrs Pretty brought a claim against the United Kingdom before the European Court of Human Rights ("the ECtHR"), in which the court held that there had been no violation of any of her Convention rights. The ECtHR differed from the House of Lords, however, in holding that Mrs Pretty's Article 8(1) rights were engaged. The ECtHR said (at [67]):

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

15. It has been endorsed repeatedly in later case law of the ECtHR that such matters engage Article 8(1), for example in *Haas v Switzerland* (2011) 53 EHRR 33, *Koch v Germany* (2012) 56 EHRR 6, *Gross v Switzerland* (2013) 58 EHRR 197 and *Nicklinson v United Kingdom* (2015) 61 EHRR SE7. As a result, it was common ground between the parties in the present case.

16. Although the ECtHR disagreed with the House of Lords on that point, it agreed with the House of Lords on the application of Article 8(2), namely that section 2 was a proportionate and justified interference with Mrs Pretty's Article 8(1) rights: see [68]-[78]. In particular, the ECtHR held (at [74]):

> "… the Court finds, in agreement with the House of Lords and the majority of the Canadian Supreme Court in [*Rodriguez v Attorney General of Canada* [1994] 2 LRC 136], that States are entitled to regulate through the operation of the general criminal law activities which are detrimental to the life and safety of other individuals (see also Laskey, Jaggard and Brown, cited above, pp. 132-33, § 43). The more serious the harm involved the more heavily will weigh in the balance considerations of public health and safety against the countervailing principle of personal autonomy. The law in issue in this case, section 2 of the 1961 Act, was designed to safeguard life by protecting the weak and vulnerable and especially those who are not in a condition to take informed

> decisions against acts intended to end life or to assist in ending life. Doubtless the condition of terminally ill individuals will vary. But many will be vulnerable and it is the vulnerability of the class which provides the rationale for the law in question. It is primarily for States to assess the risk and the likely incidence of abuse if the general prohibition on assisted suicides were relaxed or if exceptions were to be created. Clear risks of abuse do exist, notwithstanding arguments as to the possibility of safeguards and protective procedures."

17. The ECtHR subsequently made clear in *Nicklinson v United Kingdom* (at [84]), that this was the kind of case that fell within a state's margin of appreciation, giving Parliament discretion to legislate as it had done.

Post-Pretty parliamentary engagement with section 2 and questions of assisted suicide

18. Following *Pretty*, Parliament considered the relevant issues on five separate occasions. First, Lord Joffe attempted unsuccessfully to persuade Parliament to pass legislation in the form of the Assisted Dying for the Terminally Ill Bill between 2003 and 2006 (the "Joffe Bill"). This sought to legalise medical assistance for people who were unable to kill themselves without the assistance to do so where they were terminally ill, mentally competent and suffering unbearably and would also have legalised euthanasia for those who were physically incapable of carrying out the final action to end their lives by way of suicide.

19. Secondly, a House of Lords Select Committee examined the Joffe Bill and the issues surrounding it, publishing its report on 4 April 2005 (HL Paper 86-I, 2005). The Select Committee called for evidence from a large number of organisations and invited contributions from individuals. Transcripts of the extensive oral evidence are publicly available.

20. The Select Committee recognised the principle of personal autonomy and noted that the supporters of the Joffe Bill believed that persons should have the right, subject to prescribed safeguards, to have medical assistance to die in the same way as patients already have the right to refuse life-prolonging treatment. It also observed that opponents argued that the two situations were not comparable, that it would be impossible to ensure that any safeguards were not abused and that in any event the law should not permit intentional killing, whatever the motive.

21. The Committee recorded conflicting views about the likely effect of the Joffe Bill in giving benefit to some and risking harm to others and about the risk of a change in the law leading to a "slippery slope" of assisted suicide or euthanasia in unsuitable cases, which some argued could be mitigated by effective safeguards. The Select Committee also noted a division of views about whether the Joffe Bill would improve or undermine the trust which underpins doctor-patient relationships and about whether medical practitioners would be prepared to implement such a Bill were it to become law. The Select Committee recorded the suggestion that the Joffe Bill would put some vulnerable groups of people, such as the disabled and the elderly, at greater risk, while noting opinion polls which suggested that the majority of people in those groups supported legislative change.

22. The Select Committee members visited three foreign jurisdictions which had enacted laws to permit assisted suicide, namely the State of Oregon in the USA, the Netherlands and Switzerland. The Select Committee noted that recent opinion polls in those places had suggested a high level of support for these laws, that such polls had generally taken the form of yes/no questions and that the attitude of medical professionals was ambivalent but more generally hostile.

23. The Select Committee's post-bag suggested a narrow majority in favour of the Joffe Bill. The Committee issued its report with recommendations, acknowledging that the Joffe Bill would not progress due to shortage of time in Parliament. It invited Parliament to debate its report and suggested that a further committee of the whole House of Lords should consider any further Bill seeking to change the law.

24. Thirdly, there was an adjournment debate on assisted dying in the House of Commons on 11 November 2008.

25. Fourthly, in July 2009, during the debate on the Bill which became the Coroners and Justice Act 2009 ("the 2009 Act"), which amended section 2 of the 1961 Act in certain respects, Lord Falconer of Thoroton moved an amendment that would have removed the threat of prosecution from those who assist terminally ill people to travel to countries where assisted dying is legal. During the July 2009 debate on that Bill the amendment was defeated in the House of Lords. The House of Lords instead approved the clause which became section 59 in the 2009 Act, which preserved the effect of section 2 of the 1961 Act and re-enacted section 2(1) in clearer terms.

26. Fifthly, the House of Commons went on to approve the relevant clause which became section 59 of the 2009 Act in a brief debate, during which the purpose of that provision to preserve the effect of section 2 of the 1961 Act was explained.

The Purdy case

27. The next case of relevance was *R (Purdy) v Director of Public Prosecutions* [2009] UKHL 45, [2010] 1 AC 345 ("*Purdy*"). The facts of that case were that Ms Purdy suffered from primary progressive multiple sclerosis, a condition for which there was no known cure. She needed an electric wheelchair and had lost the ability to carry out many basic tasks for herself. She wished, at a time when her continuing existence would become unbearable, to end her life while she would still be physically able to do so but would require the assistance of another person. She wanted to travel to a country where assisted suicide was lawful. Her husband was willing to help her make that journey. By doing so, however, her husband would run a substantial risk of prosecution under section 2(1) of the 1961 Act, a risk they both wanted to ensure to avoid as far as possible.

28. Ms Purdy's claim concerned section 2(4) of the 1961 Act which precludes, except with the consent of the DPP, any prosecution of a person who has allegedly contravened section 2(1). Mrs Purdy wished to obtain information from the DPP as to his likely attitude to a prosecution of her husband in those circumstances. That was information which he had declined to give.

29. The House of Lords followed the ECtHR's decision in *Pretty v United Kingdom* in holding that Ms Purdy's Article 8(1) rights were engaged. The House of Lords held that her Article 8 rights were infringed by the DPP's refusal to give to her the information requested. Given that her rights were engaged, Article 8 required that "the law must indicate with sufficient clarity the scope of any such discretion conferred on the competent authorities and the manner of its exercise": Lord Hope at [43], quoting from *Hasan and Chaush v Bulgaria* (2000) 34 EHRR 1339. The House of Lords rejected the DPP's argument that his Code for Crown Prosecutors, which applied to all crimes and was issued pursuant to section 10 of the Prosecution of Offences Act 1985, furnished Ms Purdy with sufficient guidance. As Lord Hope said (at [56]), the DPP should be required to

> "… promulgate an offence-specific policy identifying the facts and circumstances which he will take into account in deciding, in a case such as that which Ms Purdy's case exemplifies, whether or not to consent to a prosecution under section 2(1) of the 1961 Act."

Post-Purdy parliamentary engagement with s.2 and questions of assisted suicide

30. Following the House of Lords' decision in *Purdy*, the DPP produced a draft policy which was the subject of wide consultation and which was finalised in 2010. This policy was the first iteration of the DPP's current "Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide" ("the DPP's Policy"). Parliament went on to engage with the relevant issues on four occasions. First, in March 2012, there was a debate in the House of Commons on the DPP's Policy. Changes in the law were mooted, but in the event the reformulated Policy was approved on a motion put to a vote. Secondly, on 5 December 2013 a question for short debate on assisted dying was put before the House of Lords. Thirdly, on 12 December 2013 there was a debate in the House of Lords about end of life care which included debate about section 2(1) of the 1961 Act. Fourthly, on 5 March 2014 there was a debate in the House of Lords about prosecution policy, which again included debate about section 2(1).

The Nicklinson case

31. Prior to the present case, *R (Nicklinson) v Ministry of Justice* [2014] UKSC 38, [2015] AC 657 ("*Nicklinson*"), was the most recent challenge to the 1961 Act.

32. An important part of the background to *Nicklinson* in the Supreme Court was the introduction by Lord Falconer of his Assisted Dying Bill in the House of Lords ("the Falconer Bill") on 5 June 2014, shortly before the judgment in the Supreme Court was delivered.

33. The facts in *Nicklinson* were as follows. Two of the claimants in that case (Mr Nicklinson and Mr Lamb) suffered from irreversible physical disabilities amounting to "locked in syndrome". This meant that they were almost completely immobile, although they remained of sound mind and were aware of their predicament. Mr Nicklinson had been placed in this condition as the result of a stroke; Mr Lamb as the result of a car accident. Their disabilities prevented them from being able to carry out themselves any act to commit suicide, even with assistance from others. An important part of their case was that, in order to respect their Article 8 rights, the law ought to

allow a third party to take action to end their lives, in other words the legalisation of euthanasia as distinct from the legalisation of assistance with suicide. Amongst other relief, they sought a declaration of incompatibility with their Article 8(1) rights in respect of section 2(1). The third claimant, Mr Martin, was also in a state broadly equivalent to "locked in syndrome". He retained the capacity to make limited hand movements and could commit an act of suicide, but only with the assistance of a third party. His case differed from that of Mr Nicklinson and Mr Lamb in that he wanted the DPP to clarify and modify the published policy guidance for prosecutors in respect of cases of encouraging or assisting suicide so that his carers and others could know that they could assist him in committing suicide through use of the Dignitas service in Zurich, Switzerland, without the risk of being prosecuted. For the purposes of the present case, it is necessary to refer only to the position of Mr Nicklinson and Mr Lamb.

34. In order to give a flavour of the lines on which the Justices were either united or disagreed with one another, it is convenient to set out here the following analysis by the Divisional Court of the Supreme Court judgments in *Nicklinson*:

> "85. The nine justices in the Supreme Court were divided in their views about this along a spectrum. As we read their judgments, and subject to certain differences in nuance between them, (a) Lord Sumption JSC (see in particular [233]-[234]), Lord Hughes JSC (in particular at [267]) and Lord Reed JSC (in particular at [196]-[298]) considered that no incompatibility of section 2 with Article 8 could be found as a matter of substance; (b) Lord Neuberger PSC (in particular at [113]-[118]), Lord Mance JSC (in particular at [188] and [190]-[191], Lord Wilson JSC (in particular at [196]-[197]) and Lord Clarke of Stone-cum-Ebony JSC (in particular at [293]) took the view that given that Parliament was on the point of debating the Falconer Bill it would be premature for the court to consider making a declaration of incompatibility until Parliament had had the opportunity to consider the issues for itself in that debate (at [293] Lord Clarke gave a stronger indication of the ultimate outcome of any application for a declaration of incompatibility if Parliament did so – in line with the justices in group (a) - than did Lord Neuberger, Lord Mance and Lord Wilson, who were at pains to emphasise that the question of incompatibility would be at large and would have to be considered afresh after any parliamentary debate: see [118], [191] and [197(f)] respectively); and (c) Baroness Hale of Richmond DPSC (at [299]-[321]) and Lord Kerr of Tonaghmore JSC (at [326]-[361]), who were satisfied at that stage of the proceedings that there was an incompatibility between section 2 and the Article 8 rights of those in the position of the claimants and were prepared to grant a declaration of incompatibility then and there. Lord Kerr considered that, among other reasons for finding an incompatibility, there was no rational connection between the aim of the legislation, taken as the protection of the vulnerable,

and the interference with the Article 8 right constituted by section 2: [349]-[351] and [361]. But no other justice concurred in that view.

86. The views of the justices in group (a) reflected what they regarded as the importance of and respect due to Parliament's legislative choice in light of the controversial social and moral dimensions of the question whether section 2 should be amended, what procedures might be put in place to mitigate the indirect consequences of legalising assisted suicide and whether any remaining risks were acceptable: see in particular [233]-[234] (Lord Sumption). Other justices also accepted that these considerations were relevant to any determination regarding the compatibility of section 2 with Article 8: see in particular Lord Mance at [164], [166]-[170] and [189]-[190] ("Parliament is certainly the preferable forum in which any decision should be made, after full investigation and consideration, in a manner which will command popular acceptance"); [115] per Lord Neuberger; [201] per Lord Wilson (the area is one "in which the community would expect its unelected judiciary to tread with the utmost caution"); and [300] per Baroness Hale ("Like everyone else, I consider that Parliament is much the preferable forum in which the issue should be decided").

87. The views of the justices in group (b), in deciding to defer the question of compatibility until after further debate in Parliament, reflected the importance of Parliament as a decision-maker in this morally and socially sensitive area but also their hopes that Parliament would take into account the points raised in the judgments in the Supreme Court when deciding what to do about section 2: see [113] (Lord Neuberger), [190] (Lord Mance), and [197], [202] and [204]-[205] (Lord Wilson). …

…

89. … In our view, the judgments of the justices in group (b) in *Nicklinson* were based on the fact that it was known that a specific Bill was before Parliament so that the issues arising were due to be debated there in the near future. In those circumstances the justices in group (b) were prepared to postpone proceeding to a final determination of the issue of compatibility themselves. That was an unusual course to take, since normally a court will proceed to determine a properly arguable claim which is presented to it. The proper role of the court is to protect the rule of law and this means determining legal claims which are brought. The unusual course of postponement of dealing with the question of compatibility which the justices in group (b) in Nicklinson favoured was

> justified by the special and unusual circumstances pertaining at the time of the decision."

35. In summary, all of the Justices, other than Lady Hale and Lord Kerr, dismissed the appeals and declined to issue a declaration of incompatibility.

36. On this appeal Ms Nathalie Lieven QC, for Mr Conway, took issue with certain aspects of the Divisional Court's analysis of the judgments in the Supreme Court in *Nicklinson*. We address her submissions below.

37. Subsequently, in *Nicklinson v United Kingdom*, Mr Nicklinson's widow (Mr Nicklinson having died in the course of the proceedings before the domestic courts), on both her own and her late husband's behalf, and Mr Lamb lodged applications with the ECtHR. For the purposes of the present case, it is necessary to refer only to the position of Mrs Nicklinson. She contended that the domestic courts had violated both her and her late husband's Article 8(1) rights by refusing to determine the compatibility of section 2(1) with their right to respect for private life.

38. As noted above, the ECtHR clarified what it had said in *Pretty* and repeated that this kind of case falls within a member state's margin of appreciation. The court went on to hold that it was inappropriate to impose on member states a procedural obligation to require courts to decide on the merits of such a claim (as opposed to deferring to the legislature). The court said, in particular (at [84]):

> "… If the domestic courts were to be required to give a judgment on the merits of such a complaint this could have the effect of forcing upon them an institutional role not envisaged by the domestic constitutional order. Further, it would be odd to deny domestic courts charged with examining the compatibility of primary legislation with the Convention the possibility of concluding, like this Court, that Parliament is best placed to take a decision on the issue in question in light of the sensitive issues, notably ethical, philosophical and social, which arise. …"

39. In any event, the ECtHR was satisfied that the majority of the Justices in *Nicklinson* had dealt with the substance of the claim. It held (at [85]) that the fact that, in making their assessment, the majority had attached very considerable weight to the views of Parliament did not mean that they had failed to carry out any balancing exercise. The court found (at [86]) that Mrs Nicklinson's application was manifestly ill-founded, and declared it to be inadmissible.

40. Following the decision of the Supreme Court in *Nicklinson*, in 2014 the DPP clarified the DPP's Policy: that clarification concerned the position of medical or healthcare professionals, professional carers and those in authority. There was then a challenge to that amendment which failed: see *R (Kenward and Kenward) v DPP and HM Attorney General* [2015] EWHC 3508 (Admin), [2016] 1 Cr App R 16. Rather than set out the public interest factors tending in favour of a prosecution, it is sufficient to identify those tending against prosecution which are in these terms, as outlined in paragraph 45 of the DPP's Policy:

> "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."

Post-Nicklinson parliamentary engagement with section 2 and questions of assisted suicide

41. Following the Supreme Court's judgment in *Nicklinson,* Parliament has considered the relevant issues on the following occasions.

42. The Falconer Bill, which had been prepared following research and analysis by a body referred to as the Falconer Commission, received its second reading on 18 July 2014. There were 10 hours of debate but no vote. The Falconer Bill was debated for two days in committee in November 2014 and January 2015. Parliament was prorogued before the Bill made any further progress in the 2014-2015 session.

43. In June 2015 Rob Marris MP tabled a Private Members' Bill, the Assisted Dying (No 2) Bill ("the Marris Bill"), in the House of Commons. It was in materially similar terms to the Falconer Bill. It was debated in the House of Commons on 11 September 2015 for 4 hours and 18 minutes. It was rejected by 330 votes to 118.

44. On 3 June 2015 Lord Falconer introduced an Assisted Dying Bill in the House of Lords in materially similar terms to his earlier Bill. It was not given time for debate due to its position on the ballot for Private Bills.

45. On 9 June 2016, Lord Hayward introduced an Assisted Dying Bill in the House of Lords ("the Hayward Bill") in materially similar terms to the Falconer Bill. Parliament was dissolved before it had its second reading.

46. On 16 January 2017 there was a brief debate following a question in the House of Lords about whether the Government had any plans to legalise assisted dying for terminally ill adults with mental capacity, with appropriate safeguards.

47. On 6 March 2017, there was a short debate in the House of Lords on the question of the Government's assessment of recent legislation on assisted dying in North America and whether such laws might provide an appropriate basis for legislation in England and Wales.

48. The Falconer Bill, the Marris Bill and the Hayward Bill, which are all in materially similar terms, would have legalised assisted dying for those who could: demonstrate a voluntary, clear, settled and informed wish to end their own life; are aged 18 or over; have capacity to make the decision to end their own life; have made and signed a declaration to that effect in the presence of an independent witness, where the declaration is also signed by the witness and two suitably qualified medical practitioners; have been ordinarily resident in England and Wales for not less than a year; have been diagnosed by a registered medical practitioner as having an inevitably progressive condition which could not be reversed by treatment and as a consequence of which they are reasonably expected to die within six months; and where the consent of the High Court has been obtained. These Bills had features which were different from the Joffe Bill, in particular the requirement that there be a prognosis of death within six months, the absence of a requirement that the individual be subject to unbearable suffering and the addition of a requirement to obtain the consent of the High Court in each case.

The Procedural History of the Present Proceedings

49. On 19 December 2016 Mr Conway filed his claim form for judicial review, in which he sought a declaration under section 4(2) of the HRA that section 2(1) of the 1961 Act is incompatible with his rights under Article 8. The Divisional Court (Burnett LJ (as he then was) and Jay J, Charles J dissenting) refused permission to bring judicial review proceedings by an order of 21 March 2017: *R (Conway) v Secretary of State for Justice* [2017] EWHC 640 (Admin). That was reversed by order of the Court of Appeal (Beatson and McFarlane LJJ) dated 12 April 2017, which granted permission for Mr Conway to bring his judicial review claim: *R (Conway) v Secretary of State for Justice* [2017] EWCA Civ 275.

50. On 5 October 2017 the Divisional Court (Sales LJ, Whipple and Garnham JJ) handed down their judgment dismissing Mr Conway's claim for judicial review: *R (Conway) v Secretary of State for Justice* [2017] EWHC 2447 (Admin), [2018] 2 WLR 322.

Judgment Under Appeal

The Divisional Court arguments in outline

51. The principal arguments of Mr Conway before the Divisional Court were as follows. First, he argued that section 2(1) is a blanket ban on the provision of assistance for suicide which constitutes an interference with his Article 8(1) rights in a way which is disproportionate and incompatible with Article 8(2). Secondly, he proposed an alternative statutory scheme which, he argued, would sufficiently protect the weak and vulnerable in society and thereby demonstrate that the blanket prohibition in section 2(1) is an unnecessary and disproportionate interference with his Article 8(1) rights. Thirdly, he argued that, to give proper respect to their Article 8(1) rights, the section 2(1) prohibition should be modified to allow himself and others within the category of individuals proposed by him under his scheme to be provided with

assistance in the form he describes so as to be enabled to commit suicide by their own action. He contended, finally, on the basis that the wording of section 2(1) is clear in its meaning and effect, that no alternative interpretation can be given to it pursuant to section 3 of the HRA, and so the court should grant a declaration of incompatibility under section 4 of the HRA.

52. The criteria and safeguards proposed under Mr Conway's alternative statutory scheme are materially similar to those in the Falconer Bill, the Marris Bill and the Hayward Bill and are as follows:

1) The prohibition on providing assistance for suicide should not apply where the individual:

a) is aged 18 or above;

b) has been diagnosed with a terminal illness and given a clinically assessed prognosis of six months or less to live;

c) has the mental capacity to decide whether to receive assistance to die;

d) has made a voluntary, clear, settled and informed decision to receive assistance to die; and

e) retains the ability to undertake the final acts required to bring about his or her death having been provided with such assistance.

2) The prohibition would only be disapplied where the following procedural safeguards are satisfied:

a) the individual makes a written request for assistance to commit suicide, which is witnessed;

b) his or her treating doctor has consulted with an independent doctor who confirms that the substantive criteria in (1) are met, having examined the patient;

c) assistance to commit suicide is provided with due medical care; and

d) the assistance is reported to an appropriate body.

3) Finally, as a further safeguard, permission for provision of assistance should be authorised by a High Court judge, who should analyse the evidence and decide whether the substantive criteria in (1) are met in that individual's case.

The Divisional Court's findings and conclusions

53. We do not propose to set out in detail the closely reasoned analysis in the careful and comprehensive judgment of the Divisional Court. It is sufficient, for the purposes of our judgment, to mention the following aspects of the Divisional Court's judgment.

54. The Divisional Court observed that, if Mr Conway wishes to die, he could lawfully act upon that wish by communicating his desire for his NIV equipment to be

removed. The Divisional Court found on the basis of expert evidence that, upon the withdrawal of NIV, effective symptom management and medication can be given to ensure that the patient is not aware of the NIV being withdrawn and to prevent and manage breathlessness, discomfort and distress for the patient.

55. The Divisional Court highlighted material factual differences between the situation of the claimants in *Nicklinson* and Mr Conway's situation, including that Mr Conway, unlike all three of the *Nicklinson* claimants, is terminally ill, and also Mr Conway, unlike Mr Nicklinson and Mr Lamb, does not wish to ask anyone else to commit the act of killing him (i.e. euthanasia) but wishes only to be enabled through third party assistance to kill himself.

56. The Divisional Court noted that, as a consequence of *Pretty* and *Nicklinson*, it was accepted between the parties in the present case that the ECtHR would find that the blanket prohibition in section 2(1) involves no violation of Article 8, and that the declaration of incompatibility sought by Mr Conway therefore only concerns the domestic law under the HRA, in accordance with the House of Lords decision in *In re G (Adoption: Unmarried Couple)* [2008] UKHL 38, [2009] 1 AC 173 ("*Re G*").

57. The Divisional Court considered the past engagement by Parliament with section 2(1) and with issues of assisted dying more generally. In particular, the Divisional Court observed that little has changed since the Select Committee Report on the Joffe Bill, and that Mr Conway's claim in these proceedings raises many of the same issues and controversies that were examined in detail and reported upon by the Select Committee. The range of evidence received and considered by the Select Committee was very wide, extending well beyond that relied on before the Divisional Court.

58. The Divisional Court went on to consider a range of evidence adduced by the parties. They considered the comparative legal position of other states in relation to assisted suicide and euthanasia. They took into account the views of various medical associations which have examined the ethical and practical issues in relation to end-of-life care and physician assisted dying, and concluded that the concerns expressed by responsible professionals dealing with patients on the front line of clinical practice cannot be regarded as unreasonable or without foundation. The Divisional Court found that there is a real risk that a change in the law to legalise provision of assistance for suicide could have a serious detrimental effect on trust between doctors and patients. They noted the concerns of other associations, bodies and witnesses opposing any move to change the existing laws on assisted dying. They also considered a range of expert medical reports.

59. The Divisional Court rejected the submission on behalf of the SoS that they were bound by *Pretty* to dismiss Mr Conway's claim.

60. The Divisional Court also considered that they were not formally bound by *Nicklinson* to decide the present case in a particular way since the majority of the Supreme Court (Lords Neuberger, Mance, Wilson and Clarke) reached their decision in a particular context, where it was known that a specific bill (the Falconer Bill) was before Parliament so that the issues arising were due to be debated imminently.

61. The Divisional Court considered that there were three legitimate aims promoted by section 2(1) which were sufficiently important to justify limiting Mr Conway's

fundamental rights under Article 8(1). The first was the protection of the weak and vulnerable. The second was the protection of the sanctity of life as a moral principle. The third was the promotion of trust and confidence between doctor and patient, which encourages patients to seek and then act upon medical advice. The Divisional Court went on to conclude that there clearly is a rational connection between the prohibition in section 2(1) and all three of those legitimate aims.

62. The Divisional Court proceeded to hold that section 2(1) is necessary to promote the aim of protecting the weak and vulnerable. It considered that the proposed involvement of the High Court in checking capacity and absence of pressure or duress does not meet the real gravamen of the case for protecting the weak and vulnerable. The Divisional Court quoted paragraph [228] of Lord Sumption's judgment in *Nicklinson* concerning the near impossibility of distinguishing between those who have spontaneously formed the desire to kill themselves and those who have done so in response to real or imagined pressure arising from the impact of their disabilities on other people and covert social pressures.

63. The Divisional Court held that there are powerful constitutional reasons as to why the court should respect Parliament's assessment of the necessity of section 2(1), where it has made its own evaluative assessment with the benefits of the judgments in *Nicklinson*. The Divisional Court referred to Parliament's democratic mandate, and its role as the conscience of the nation, to make the relevant assessment in a finely balanced and controversial case involving important elements of social policy and moral value-judgement.

64. The Divisional Court held that section 2(1) strikes a fair balance between the three legitimate aims which represent the interests of the wider community and the rights of people in the position of Mr Conway as to the timing and manner of their death.

65. For those, and other detailed reasons, the Divisional Court found section 2(1) to be compatible with Mr Conway's Article 8 rights and dismissed his application for a declaration of incompatibility.

The Appeal to the Court of Appeal

Grounds of appeal and cross appeal

66. After handing down their judgment, the Divisional Court refused permission to appeal. In a judgment handed down on 18 January 2018 Sir Ernest Ryder SPT and Underhill LJ granted Mr Conway permission to appeal to the Court of Appeal: *R (Conway) v Secretary of State for Justice* [2018] EWCA Civ 16.

67. Mr Conway appealed on seven grounds which were grouped within three main issues of principle. The first issue concerned the correct way in which the court should respond to Parliament's decision not to amend section 2(1) of the 1961 Act and the proper approach to be taken when assessing the proportionality of section 2(1). This issue encompassed grounds one and three of the appeal, which were respectively that the Divisional Court had misdirected themselves as to the correct legal test to apply under Article 8(2) and that they had also misdirected themselves in law as to the approach to take when assessing whether section 2(1) is more than "necessary" for the purposes of Article 8(2).

68. The second issue concerned the way in which the Divisional Court addressed Mr Conway's proposed safeguards. This encompassed grounds two, four and six of the appeal, which were respectively that the Divisional Court had adopted a legally flawed approach to the evidence, had failed to address significant evidence and material relating to the strength of the proposed safeguards, and had misdirected themselves as to the approach to take in identifying whether section 2(1) strikes a fair balance between the rights of Mr Conway and the interests of the community for the purposes of Article 8(2).

69. The third issue concerned the weight to be placed on personal autonomy. This encompassed grounds five and seven of the appeal, which were respectively that the Divisional Court had failed to address the consequence of the accepted presence of "biased decision-making" in treatment refusal decisions and had also failed to address the legal and moral differences between a request for assistance with dying and a request for euthanasia.

70. Finally, if the Divisional Court was found to have made any errors of principle in relation to those three issues, the Court of Appeal was then invited to retake the proportionality assessment itself.

71. By his respondent's notice dated 1 February 2018, the SoS cross appealed on two grounds. The first was that the Divisional Court had erred in concluding that *Pretty* is not binding authority that section 2(1) does not infringe Mr Conway's Article 8(1) rights. The second was that it is institutionally inappropriate for the courts, rather than Parliament, to consider the compatibility of section 2(1) with Article 8.

The interveners

72. In addition to the two parties, we granted permission by order dated 17 April 2018 for three organisations to intervene in this appeal, all of which had also intervened in the Divisional Court proceedings.

73. The first, Humanists UK, contended that the appeal should be allowed and a declaration of incompatibility as sought by Mr Conway should be made. Humanists UK has long-standing experience and expertise in relation to issues of assisted dying. They also have a valuable interdisciplinary expertise, at the intersection of medical ethics, moral philosophy and law, and their work is said to be informed by the support of over 150 of the UK's most prominent philosophers, scientists and other experts.

74. The second, Not Dead Yet UK ("NDYUK"), argued for dismissal of the appeal. NDYUK is a membership organisation of disabled and terminally ill people with physical and sensory impairments, learning difficulties and mental illness, all of whom have combined efforts to campaign against the legalisation of assisted suicide.

75. The third, Care Not Killing ("CNK"), also argued for the dismissal of the appeal. CNK is an alliance of individuals and about 20 organisations interested in disability, human rights, health care, and palliative care. One of their core aims is to ensure that existing laws against euthanasia and assisted suicide are not weakened or repealed.

The submissions for Mr Conway

76. We set out here the submissions in support of the appeal. We focus particularly on the extensive submissions of Ms Lieven, for Mr Conway. We were grateful to receive submissions from Humanists UK in support of the appeal but do not consider that they added materially to Ms Lieven's submissions. We refer to the submissions of Humanists UK where appropriate.

77. The starting point of Ms Lieven's submissions was that the issue under Article 8(2) is a focused one, namely whether the interference with Mr Conway's Article 8 rights constituted by section 2(1) of the 1961 Act is justified and proportionate in order to protect weak and vulnerable persons. She said that the need for such protection was the principal point put forward by the SoS both in *Pretty* and in *Nicklinson.* She submitted that the court is, therefore, not concerned with questions of morality or ethics. Put a different way, the question is whether the scheme put forward by Mr Conway is adequate protection for the weak and vulnerable.

78. Ms Lieven's principal criticism of the Divisional Court is that, in carrying out the assessment of justification and proportionality under Article 8(2), the Divisional Court gave excessive deference, or in her words "overwhelming deference" to Parliament. Ms Caoilfhionn Gallagher QC, for Humanists UK, submitted that, in effect, the Divisional Court found themselves institutionally incapable of determining Mr Conway's claim and failed to carry out the exercise under Article 8(2). Both Ms Lieven and Ms Gallagher maintained that the Divisional Court, by simply adopting the balance struck by Parliament, had effectively abdicated their constitutional responsibility under the HRA to make the proportionality assessment for themselves.

79. Ms Lieven drew attention, in particular, to the following statements by the Divisional Court. In paragraph [76] the Divisional Court said:

> "… The question at issue is whether Parliament has a proper basis for maintaining in place the prohibition against provision of assistance for suicide contained in section 2. …"

80. In paragraph [106] the Divisional Court said that, in order to decide whether the blanket prohibition in section 2 is necessary to promote the legitimate aim of protecting the weak and vulnerable, an evaluative judgement is required to make an assessment as to how people would behave and how society might be affected if section 2 were amended. The Divisional Court continued:

> "… Parliament has made the assessment that it is. The evidence we have received shows that there is a serious objective foundation for that assessment. …"

81. In paragraph [110] the Divisional Court said that Parliament is better placed than the court to make the relevant assessment regarding the likely impact of changing the law in the matter. They said that the consideration given by Parliament through its processes (including Select Committee investigation and reports) to the issue of assisted dying over the years has been more thorough and extensive than would be achieved in a court hearing to determine the issues of law. The Divisional Court then quoted the following passage from paragraph [232] of the judgment of Lord Sumption in *Nicklinson*:

> "… the parliamentary process is a better way of resolving issues involving controversial and complex questions of fact arising out of moral and social dilemmas. The legislature has access to a fuller range of expert judgment and experience than forensic litigation can possibly provide. It is better able to take account of the interests of groups not represented or not sufficiently represented before the court in resolving what is surely a classic "polycentric problem". But, perhaps critically in a case like this where firm factual conclusions are elusive, Parliament can legitimately act on an instinctive judgment about what the facts are likely to be in a case where the evidence is inconclusive or slight: see *R (Sinclair Collis Ltd) v Secretary of State for Health* [2012] QB 394, especially at para 239 (Lord Neuberger of Abbotsbury MR), and *Bank Mellat v HM Treasury (No. 2)* [2014] AC 700, 795-796, paras 93-94, per Lord Reed. Indeed, it can do so in a case where the truth is inherently unknowable, as Lord Bingham thought it was in *R (Countryside Alliance) v Attorney General* [2008] AC 719, para 42."

82. Ms Lieven submitted that this approach of the Divisional Court was plainly wrong for two reasons. First, it is contrary to the approach of the majority of the Justices in *Nicklinson*. Secondly, it fails to grapple with the fact that the court in the present case is at least as well-placed as, if not better-placed than, Parliament to decide on the necessity and proportionality of the blanket ban on assisted suicide in order to protect weak and vulnerable persons.

83. So far as concerns the first of those points, she said that Lords Neuberger, Mance and Wilson reached their conclusion because, as a matter of timing, the Falconer Bill was then before Parliament and would provide the opportunity for all the issues to be aired. She referred to paragraphs [115]-[118] in the judgment of Lord Neuberger, paragraphs [150], [166] and [190] in the judgment of Lord Mance and paragraphs [196] and [197(d)-(e)] in the judgment of Lord Wilson. She submitted that, when they are added to the dissenting judgments of Baroness Hale and Lord Kerr, it is clear that Lord Sumption was in the minority in his view that Parliament is the more appropriate forum than the court for deciding whether the blanket ban on assisted suicide is necessary in Convention terms, that is to say it responds to a pressing social need.

84. Ms Lieven submitted that it is the very function of the court under the HRA to consider whether section 2(1) of the 1961 Act interferes with human rights. She accepted that this does not mean that the court should never accord some respect to Parliament in an appropriate case when carrying out the proportionality exercise in assessing whether or not the interference with a qualified Convention right is justified. As to the nature and degree of respect to be given to Parliament's view in any particular case, she said that the correct approach is that of Lord Bingham in *R (Countryside) Alliance v Attorney General* [2007] UKHL 52, [2008] 1 AC 719, where he said as follows (at [45]):

> "There are of course many … who do not consider that there is a pressing (or any) social need for the ban imposed by the Act.

> But after an intense debate a majority of the country's democratically-elected representatives decided otherwise. It is of course true that the existence of duly enacted legislation does not conclude the issue … Here we are dealing with a law which is very recent and must (unless and until reversed) be taken to reflect the conscience of a majority of the nation. The degree of respect to be shown to the considered judgment of a democratic assembly will vary according to the subject matter and the circumstances. But the present case seems to me pre-eminently one in which respect should be shown to what the House of Commons decided. The democratic process is liable to be subverted if, on a question of moral and political judgment, opponents of the Act achieve through the courts what they could not achieve in Parliament."

85. Ms Lieven submitted that, in the present case, the court is even better placed than Parliament to form a view about the adequacy of Mr Conway's proposed scheme.

86. Mr Conway has proposed the particularised scheme summarised at paragraph [52] above to allow the court to test whether any less restrictive approach to the interference with his Article 8 rights could be practically feasible.

87. Ms Lieven submitted that a High Court judge, sitting in an inquisitorial role, is well able to decide whether the scheme's five substantive criteria are met in any particular case. She contrasted that situation with the one faced by the Supreme Court in *Nicklinson*. She observed that in paragraph [107] of *Nicklinson* Lord Neuberger had said that the court in that case was not being asked to set up a specific scheme under which the applicants could be assisted to commit suicide such that it would be disproportionate for the law to forbid them from doing so and, concurring with Lord Hughes (at [267]), that it was a matter for Parliament to determine the precise details of any scheme.

88. She criticised the way in which the Divisional Court had evaluated the medical expert evidence in paragraphs [74] and [75] of their judgment. She said that the Divisional Court's evaluation was completely unbalanced and unfair and wholly failed to address the detailed evidence submitted on behalf of Mr Conway criticising the evidence of Professor Baroness Finlay of Llandaff, a consultant physician and professor of palliative medicine, who wrote an expert report for the SoS.

89. The Divisional Court referred to Professor Finlay's evidence in paragraph [75] of their judgment. They mentioned that she referred to a survey of 1000 GPs in 2015 which revealed that only 14% of respondents would be prepared to assess an individual who wished to have assistance from a doctor to commit suicide. They commented that she also referred to experience in Oregon of a pattern of "doctor shopping" to find doctors willing to prescribe fatal doses of drugs, and that she relied upon those materials to support her view that a similar pattern would be likely to develop in this country if the prohibition in section 2 were relaxed. Ms Lieven criticised the Divisional Court for failing to refer to the later evidence of Professor Finlay in paragraphs 90 and 91 of her report, in which she said that, if requests for assisted suicide were considered in the Family Division, with evidence being obtained and tested from the various interests involved, including doctors, mental health

professionals, social workers, family and applicants themselves, such a process would allay her concern of doctor-shopping and would ensure a more objective assessment in each case. The Divisional Court also did not point out that Oregon did not have the equivalent of the High Court safeguard proposed in Mr Conway's scheme. Ms Lieven observed that Professor Finlay did not address the witness statements filed on behalf of Mr Conway, something which again the Divisional Court did not note in their judgment.

90. The Divisional Court observed in paragraph [74] of their judgment that, among other things, they had expert evidence from Professor Tom Sensky, a professor in the field of psychological medicine, regarding assessment of decision-making capacity, including for people wishing to die. Ms Lieven criticised the Divisional Court for failing to refer to the fact that precisely such an assessment had been carried out by Professor Sensky in *Re Z* [2004] EWHC 2817 (Fam), [2005] 1WLR 959.

91. In that case Mrs Z, who suffered from an incurable degenerative brain disease, wished to travel to Switzerland to commit assisted suicide. Her wish could only be carried out if her husband provided all necessary assistance in making the arrangements and accompanying her. The local authority obtained an injunction to restrain the husband from removing his wife from the jurisdiction. The injunction was discharged by Hedley J. The judge said that the court was greatly indebted to Professor Sensky, who the judge described as a distinguished consultant psychiatrist, for providing the court with a full report assessing Mrs Z's legal capacity to elect for suicide. The judge said that the report, which was accepted on all sides, clearly established, firstly, that Mrs Z had all the requisite attributes necessary to establish legal capacity to make her own decisions, and, secondly, the decision was hers alone entirely uninfluenced by outside considerations: indeed, she had long persisted in her views contrary to the expressed wishes of her family. The judge observed (at [13]) that the legal presumption in favour of capacity could have been rebutted by evidence of an inability to assimilate the issues, or fully appreciate the consequences, or of her being unduly influenced by the views of others or by undue concern for the burden that her condition imposed on others, but concluded that there was no such evidence in the case and, indeed, the evidence was all the other way. Having reached that conclusion, the judge said that, in the circumstances, Mrs Z's best interests were no business of his.

92. Ms Lieven further criticised the Divisional Court for failing to address some 17 Canadian cases decided in 2016. It is unnecessary to outline the full background to these cases (for which, see *AB v Canada (Attorney General)* 2016 ONSC 1912, at paragraphs 8-20), other than to say that they were decided in the aftermath of the decision of the Supreme Court of Canada in *Carter v Canada (Attorney General)* 2015 SCC 5. In *Carter*, the Court had struck down certain provisions of the Canadian Criminal Code which prohibited assisted suicide as incompatible with the Canadian Charter of Rights and Freedoms, to the extent that they prohibited physician-assisted death for a competent adult person who clearly consents for their life to be terminated and who has a grievous and irremediable medical condition that causes enduring suffering that is intolerable to the individual.

93. Those 17 cases arose in a context in which the Canadian equivalent of judges of the Family Division of England and Wales, for a period in 2016 after *Carter*, had to consider questions of capacity, coercion and vulnerability in the context of individual

requests for assistance with dying. It is contended on behalf of Mr Conway that the context of those cases was one in which the consequences were arguably even graver than those envisaged under Mr Conway's scheme, as the assistance could extend to the actual administration of medication by the relevant medical professionals. Mr Conway emphasises that his case is limited to those individuals who could carry out the final act themselves. The point particularly pressed on behalf of Mr Conway, citing Perell J in *AB v Canada* at paragraph 34, is that the judges in those cases, applying an inquisitorial approach to determining whether the criteria to even unopposed applications were met, considered that they could fulfil their mission of:

> "providing an effective safeguard against potential risks to vulnerable people. The criteria have within them safeguards to ensure that the applicant is not being coerced, controlled, or manipulated and safeguards to ensure that the applicant is making a fully-informed decision in the exercise of his or her personal autonomy, personal dignity, and free will. The criteria emphasize the personal autonomy of the applicant and that the decision is a decision of a competent adult person that clearly consents to the termination of life."

94. Ms Lieven observed, in relation to the doubts and concerns expressed by Lord Sumption at paragraph [228] of *Nicklinson*, that much more evidence on the issues surrounding the vulnerability of the old or terminally ill has been adduced in the present case than in *Nicklinson*. Mr Conway's complaint is that the evidence was not fairly assessed by the Divisional Court. She submitted that, insofar as there may be issues around the precise safeguards necessary to protect vulnerable persons, a declaration of incompatibility would enable Parliament to consider all relevant matters following consultation. She said, for example, that it would be possible to devise a structure which would enable the evidence to be fully tested, whether by the appointment of an advocate to the court or in some other way. She pointed out that both Lord Neuberger and Lord Hughes had said in *Nicklinson* (at [107] and [267] respectively) that it would be a matter for Parliament to determine the precise details of any scheme permitting assistance to commit suicide.

95. Ms Lieven referred to a number of cases which, she said, demonstrated the willingness of the court to give effect to the autonomy of a person in a termination of life situation while being assiduous to establish mental capacity and freedom from undue influence. She mentioned four cases in particular.

96. The claimant in *Re B* [2002] EWHC 429 (Fam), [2002] 2 All ER 449, was a tetraplegic, who was entirely dependent on a ventilator. She gave formal instructions to the hospital through her solicitors that she wished artificial ventilation to be removed, even though she realised that that would almost certainly result in her death. She was assessed as being competent to make the decision to discontinue treatment. The treating clinicians were not prepared to turn off the ventilator. She applied to the court for, among other things, a declaration that she had been treated unlawfully. It was held by Dame Elizabeth Butler-Sloss P that the right of a competent patient to request the cessation of treatment had to prevail over the desire of the medical and nursing profession to try to keep her alive. She said (at [94]):

> "… Unless the gravity of the illness has affected the patient's capacity, a seriously disabled patient has the same rights as the fit person to respect for personal autonomy. There is a serious danger, exemplified in this case, of a benevolent paternalism, which does not embrace recognition of the personal autonomy of the severely disabled patient. …"

97. The court granted appropriate declarations and made an award of damages.

98. In *King's College Hospital NHS Foundation Trust v C* [2015] EWCOP 80, [2016] COPLR 50, a patient refused to consent to renal dialysis even though, without such treatment, the almost inevitable outcome was her death. MacDonald J refused the application of the hospital for a declaration that she lacked capacity to make decisions about her medical care and treatment and for a declaration that the hospital and its staff were authorised to provide such medical care and treatment to her as they judged to be uniquely indicated. The judge concluded that the patient did have capacity to decide whether or not to consent to dialysis. He said (at [28]) that a person is not to be treated as unable to make a decision merely because he or she makes a decision that is unwise. He continued (at [30]):

> "… The fact that a decision not to have life-saving medical treatment may be considered an unwise decision and may have a fatal outcome is not of itself evidence of a lack of capacity to take that decision, notwithstanding that other members of society may consider such a decision unreasonable, illogical or even immoral, that society in general places cardinal importance on the sanctity of life and that the decision taken will result in the certain death of the person taking it. To introduce into the assessment of capacity an assessment of the probity or efficacy of a decision to refuse life-saving treatment would be to introduce elements which risk discriminating against the person making that decision by penalising individuality and demanding conformity at the expense of personal autonomy in the context of a diverse, plural society which tolerates a range of views on the decision in question."

99. The claimant in *Re L (No. 2)* [2012] EWCA Civ 253, [2012] 3 WLR 1439 was a local authority providing health care and social support to an elderly lady living with her husband in a house which he owned. The local authority had recorded incidents of alleged physical assault and verbal threats against them by their son, who lived in the house. The local authority also had evidence suggesting that the son was controlling access to the house by health and social care professionals, was seeking to coerce his father into transferring the ownership of the house to him and was putting pressure on his parents for his mother to be placed in a care home. The local authority brought proceedings seeking an injunction to restrain the son's behaviour. Neither parent supported the proceedings. By the time of the substantive hearing the father had ceased to have capacity within the meaning of the Mental Capacity Act 2005 ("the MCA"). The Court of Appeal upheld the order of the first instance judge restraining the son's behaviour towards his parents, care staff and other professionals under the inherent jurisdiction of the court and the MCA. McFarlane LJ said (at [65]) that, where an individual does not lack capacity in the terms of the MCA but other factors,

such as coercion and undue influence, may combine with borderline capacity to remove the individual's autonomy to make an important decision, that individual should be able to access the protection of the court's inherent jurisdiction.

100. In *Re Briggs (No. 2)* [2016] EWCOP 53, [2017] 4 WLR 37 Charles J granted the wife of an incapacitated person, who was a patient in a minimally conscious state in hospital, a declaration that it was lawful and in the best interests of the patient for him to cease to be given clinically assisted nutrition and hydration ("CANH"), without which he would not survive, and to receive only palliative care at a hospice. The preferred option of the treating clinicians was that he should be moved to a rehabilitation unit where CANH would be continued. The judge said that the life of the patient did confer benefits and had value, and so the case raised fundamental issues relating to the protection of persons who are extremely vulnerable and who have not previously made and cannot now make valid and applicable decisions for themselves. The judge accepted the evidence of the patient's wife and mother, which was supported by his two brothers, as to what the patient would now want in his existing circumstances.

101. Ms Lieven took up a point mentioned by Charles J (at [20]) that an advance decision relating to life-sustaining treatment ("ADRT") under the MCA only has to be accompanied by a statement that it is to apply even if life is at risk and has to be made in writing and witnessed; so that the person making it did not have to have any particular knowledge or any particular advice. She pointed out that an ADRT could continue to apply even after the lapse of many years. By contrast, the blanket ban on assisted suicide means that a person wishing to receive such assistance cannot obtain it from a doctor, since such assistance would be a breach of the professional code of conduct and a criminal offence. Such assistance can only be obtained from family members, who would have to bear the uncertainty and risk of a retrospective decision by the DPP and the CPS as to whether or not to prosecute.

102. Ms Lieven observed that the current published guidelines in the DPP's Policy contain similar considerations (especially in paragraph 43) to those in Mr Conway's proposed scheme. She submitted that the DPP's Policy nevertheless is an unsatisfactory protection in cases of assisted suicide for the reason given by Lord Neuberger in *Nicklinson* (at [108]), namely that:

> "… A system whereby a judge or other independent assessor is satisfied in advance that someone has a voluntary, clear, settled, and informed wish to die and for his suicide then to be organised in an open and professional way, would provide greater and more satisfactory protection for the weak and vulnerable, than a system which involves a lawyer from the DPP's office enquiring, after the event, whether the person who had killed himself had such a wish, and also to investigate the actions and motives of any assistant, who would, by definition, be emotionally involved and scarcely able to take, or even to have taken, an objective view."

103. Turning to the issue of autonomy, Ms Lieven submitted that the Divisional Court plainly erred in law (at [100] and [101]) in relying on a passage from paragraph [228] of Lord Sumption's judgment in *Nicklinson* concerning indirect social pressure on the

old and terminally ill, and the difficulty of detecting it, in support of their view that the involvement of the High Court to check capacity and absence of pressure or duress does not meet the real gravamen of the case regarding the protection of the weak and vulnerable.

104. Ms Lieven submitted that what Lord Sumption said fundamentally undermines the principle of autonomy and does not accord with the long-standing authority in this area. She said that the court is well able to investigate the competence of an individual's decision, free from coercion and undue influence. She gave *Re B*, *Re Z*, the *King's College Hospital* case and *Airedale NHS Trust v Bland* [1993] AC 789 ("*Bland*") as examples of the court respecting autonomy.

105. Ms Lieven submitted that in this area of the law there are no bright lines limiting the courts' respect for autonomy. She described *Bland* as "possibly the greatest crossing of the line". In that case the patient, Anthony Bland, was in a persistent vegetative state due to serious injuries sustained in the Hillsborough football stadium disaster. The medical opinion was unanimous that there was no hope of any improvement in his condition or recovery. His father's evidence was that his son would not "want to be left like that". With the agreement of the patient's family and the doctors responsible for his care, the hospital authority sought declarations that they could lawfully discontinue all life-sustaining treatment, including termination of ventilation, nutrition and hydration by artificial means. The court granted the declarations, and that order was endorsed both by the Court of Appeal and the House of Lords. At first instance Sir Stephen Brown P said (at 797F) that the case raised for the first time in English courts the question in what circumstances, if any, could a doctor lawfully discontinue life sustaining treatment without which a patient in Anthony Bland's condition would die.

106. In a passage, which has been recognised as a classic exposition of the concepts both of sanctity of life and of autonomy, Hoffmann LJ said as follows in the Court of Appeal (at 826B-827F):

> "I start with the concept of the sanctity of life. Why do we think it would be a tragedy to allow Anthony Bland to die? It could be said that the entire tragedy took place at Hillsborough and that the curtain was brought down when Anthony Bland passed into a persistent vegetative state. Until then, his life was precious to him and his family. But since then, he has had no consciousness of his life and it could be said to be a matter of indifference to him whether he lives or dies. But the fact is that Anthony Bland is still alive. The mere fact that he is still a living organism means that there remains an epilogue of the tragedy which is being played out. This is because we have a strong feeling that there is an intrinsic value in human life, irrespective of whether it is valuable to the person concerned or indeed to anyone else. Those who adhere to religious faiths which believe in the sanctity of all God's creation and in particular that human life was created in the image of God himself will have no difficulty with the concept of the intrinsic value of human life. But even those without any religious belief think in the same way. In a case like this we should not try to

analyse the rationality of such feelings. What matters is that, in one form or another, they form part of almost everyone's intuitive values. No law which ignores them can possibly hope to be acceptable.

Our belief in the sanctity of life explains why we think it is almost always wrong to cause the death of another human being, even one who is terminally ill or so disabled that we think that if we were in his position we would rather be dead. Still less do we tolerate laws such as existed in Nazi Germany, by which handicapped people or inferior races could be put to death because someone else thought that their lives were useless.

But the sanctity of life is only one of a cluster of ethical principles which we apply to decisions about how we should live. Another is respect for the individual human being and in particular for his right to choose how he should live his own life. We call this individual autonomy or the right of self-determination. And another principle, closely connected, is respect for the dignity of the individual human being: our belief that quite irrespective of what the person concerned may think about it, it is wrong for someone to be humiliated or treated without respect for his value as a person. The fact that the dignity of an individual is an intrinsic value is shown by the fact that we feel embarrassed and think it wrong when someone behaves in a way which we think demeaning to himself, which does not show sufficient respect for himself as a person.

No one, I think, would quarrel with these deeply rooted ethical principles. But what is not always realised, and what is critical in this case, is that they are not always compatible with each other. Take, for example, the sanctity of life and the right of self-determination. We all believe in them and yet we cannot always have them both. The patient who refuses medical treatment which is necessary to save his life is exercising his right to self-determination. But allowing him, in effect, to choose to die, is something which many people will believe offends the principle of the sanctity of life. Suicide is no longer a crime, but its decriminalisation was a recognition that the principle of self-determination should in that case prevail over the sanctity of life. …

A conflict between the principles of the sanctity of life and the individual's right of self-determination may therefore require a painful compromise to be made. In the case of the person who refuses an operation without which he will certainly die, one or other principle must be sacrificed. We may adopt a paternalist view, deny that his autonomy can be allowed to prevail in so extreme a case, and uphold the sanctity of life. Sometimes this looks an attractive solution, but it can have disturbing

> implications. Do we insist upon patients accepting life-saving treatment which is contrary to their strongly held religious beliefs? Should one force-feed prisoners on hunger strike? English law is, as one would expect, paternalist towards minors. But it upholds the autonomy of adults. A person of full age may refuse treatment for any reason or no reason at all, even if it appears certain that the result will be his death."

107. Ms Lieven said that *Re B*, *Briggs* and *Re A (Children) (Conjoined Twins)* [2000] EWCA Civ 254, [2001] 2 WLR 480, were also cases where the court had developed the law in this area in approaching the value of life. *Re A* was the difficult and distressing case of the conjoined twins, in which the Court of Appeal upheld the declaration of the first instance judge permitting doctors to carry out an operation separating the twins, against the wishes of the parents, who were devout Roman Catholics, so as to attempt to save the life of one of the twins even though the operation would inevitably result in the death of the other.

108. Ms Lieven drew attention to the written Guidance published by the Association for Palliative Medicine ("the APM") for the assistance of professionals working with patients with MND. She observed that the various matters specified in the Guidance to be taken into account by a senior doctor to ensure that the patient's request for withdrawal of assisted ventilation was a settled decision of a patient with capacity are similar to the safeguards in Mr Conway's proposed scheme. She said that, in such a situation, doctors are making a physical act, at a fixed point of time, in the certain knowledge that the patient will die soon afterwards and are medicating the patient at the same time to assist the process of dying. Her argument was that such circumstances indicate that, looking at the matter from the practical position of clinicians, there is no bright line between what the law considers to be the unlawful positive act of assisted suicide, on the one hand, and facilitating the lawful withdrawal of treatment by or on the instructions of the patient, which the law characterises as a lawful omission, on the other hand.

109. She referred to the acknowledgement of Lord Neuberger in *Nicklinson* (at [94]), with whose judgment Lord Wilson agreed, that authorising a third-party to switch off a person's life support, as in *Bland* or *Re B*, is arguably in some respects:

> "… a more drastic interference to a person's life and a more extreme moral step that authorising a third party to set up a lethal drug delivery system so that a person can, but only if he wishes, activate the system to administer a lethal drug."

110. Ms Lieven's criticism of the Divisional Court was not simply, as I have said, that they wrongly accepted the views of Lord Sumption on the role of autonomy in this area, contrary to a long line of authority, and even though Lord Sumption was not supported by other Justices, but also that the Divisional Court failed to address where the line should be drawn, bearing in mind clinical reality. She said that they failed to grapple with the need for compromise between the principles of sanctity of life and

autonomy, bearing in mind the extent to which that compromise had already been made in *Re B, Bland* and other cases, that it is not a criminal offence to attempt to commit suicide, and, as Lord Neuberger observed in *Nicklinson* (at [90]), "if the primacy of human life does not prevent a person committing suicide, it is difficult to see why it should prevent that person seeking assistance in committing suicide". She submitted that the cases show that, where there is a conflict between the principle of sanctity of life, on the one hand, and the principle of personal autonomy, on the other hand, personal autonomy wins.

111. Ms Lieven adopted and endorsed the view expressed by Lord Neuberger in *Nicklinson* (at [95]) that, if the act which immediately causes the death is that of a third party that may be on the wrong side of the line, whereas if the final act is that of the person himself, who carries it out pursuant to a voluntary, clear, settled and informed decision, that is on the permissible side of the line. As he said: "In the latter case, the person concerned has not been "killed" by anyone, but has autonomously exercised his right to end his life".

112. Ms Lieven criticised the Divisional Court's analysis and conclusion (at [94]) that the evidence indicated that legalising assisted suicide would undermine the quality and efficacy of medical treatment because the evidence showed that there was a real concern among doctors and a real risk that patients (particularly vulnerable and elderly patients) would have less confidence in their doctors and the advice they might give.

113. The evidence to which the Divisional Court was referring was the report of the British Medical Association ("the BMA") published in 2015 on "End-of-life Care and Physician-Assisted Dying" ("the BMA Report"), which was summarised by the Divisional Court in paragraphs [62]-[64] of their judgment. As the Divisional Court recorded there, the research found that the majority of doctors thought that there would be a professional and emotional impact on doctors if physician-assisted dying was legalised and the majority of the impacts identified by them were negative. The BMA's research also identified considerable concern amongst doctors regarding the possibility for detrimental effects on doctor-patient relationships if physician-assisted dying were legalised, including that this would increase fear and suspicion of doctors (particularly by the disabled, frail, elderly and those who feel they are a burden) which could affect what information patients are willing to share with their doctors.

114. Ms Lieven submitted that the Divisional Court had wrongly failed to record and to take into account that the members of the public consulted by the BMA were much less concerned and gave a largely balanced range of potential positive and negative impacts on the relationship.

115. She also said that it was very unlikely that the cohort of persons represented by Mr Conway, who are dying in any event within a short time frame, would feel pressured by their doctors. She added that, if the law changed, there would no doubt be careful guidance given in a statutory code and probably also by relevant professional bodies, which would govern the conduct of doctors and the expectation of their patients. She pointed out that Professor Finlay did not express any concern about doctors pushing those in their care towards assisted suicide. Ms Lieven said that, if doctors did not wish to participate, they would not be obliged to do so, and doctors would be assisted by guidance informing them of how to conduct themselves in relation to their patients.

116. She also submitted that Mr Conway and the cohort of persons represented by him desire what is in their best interests. She said that permitting assisted suicide would, in their case, merely speed up what was happening naturally in the light of their diagnosis of suffering a terminal illness with less than six months to live. She emphasised the difference between that situation and the one under consideration in *Nicklinson*, which was concerned with the prospect of long-term suffering.

117. She submitted that the concerns of the SoS, Professor Finlay and the Divisional Court related to the impact of assisted suicide on the disabled and the elderly but, she said, they did not necessarily fall within the cohort represented by Mr Conway in these proceedings.

118. Ms Lieven rejected the concern that permitting assisted suicide for that cohort would merely be the beginning of a "slippery slope", which would mean the inexorable progression of claims to extend assisted suicide to other groups of persons. She said that no such slippery slope had been experienced in the well established existing scheme for assisted suicide in Oregon.

119. Ms Lieven criticised the Divisional Court's view in paragraphs [125]-[127] that there was force in the submission on behalf of the SoS that medical science does not permit an assessment to be made with any degree of accuracy that an individual has less than six months to live. The Divisional Court did not consider that this conclusion was defeated by the evidence of Professor Michael Barnes MD FRCP, who gave expert opinion evidence on behalf of Mr Conway. Ms Lieven submitted that the Divisional Court was wrong on that point since, she said, there was no refutation in the SoS's evidence of Professor Barnes' statement (at page 13 of his report) that it is possible to make a prediction of death within six months on the balance of probabilities applying the criteria he mentions there. She added that the guidelines that would inevitably be drawn up by professional bodies would doubtless provide a suitable checklist that would assist making a prediction.

Discussion

Preliminary observations

120. It is now well established, and common ground before us, that the right of an individual to decide how and when to end his or her life is an aspect of the right to respect for private life protected by Article 8 of the Convention: *Pretty v United Kingdom* at [67]; *Haas v Switzerland* at [5]; *Purdy* at [39]; *Nicklinson*.

121. Section 2 of the 1961 Act interferes with that right. It can only be a valid interference if it satisfies the requirements of Article 8(2), that is to say, if it is "necessary in a democratic society" for one or more of the purposes specified in Article 8(2). The purposes which are relevant in the present context are the protection of health and morals and the protection of the rights of others.

122. When considering whether legislative measures satisfy the requirements of Article 8(2), it is necessary to consider the following four questions identified by Lord Wilson in *R (Aguilar Quila) v Secretary of State for the Home Department* [2012] UKSC 45, [2012] 1 AC 621, at [45]:

> "(a) is the legislative objective sufficiently important to justify limiting a fundamental right; (b) are the measures which have been designed to meet it rationally connected to it; (c) are they no more than are necessary to accomplish it; and (d) do they strike a fair balance between the rights of the individual and the interests of the community?"

123. It is common ground before us that only (c) and (d) are relevant here.

124. The ECtHR held in both *Pretty v United Kingdom* and *Nicklinson v United Kingdom* that the blanket ban on assisted suicide in section 2 of the 1961 Act is not a violation of Article 8: it falls within the wide margin of appreciation granted to member states of the Council of Europe on this subject. The issue in these proceedings, therefore, is whether that blanket ban is a breach of Convention rights as a matter of domestic law under the HRA: see *Re G*.

125. Unlike the position in *Nicklinson*, it was not argued before us, on behalf of the SoS, that there is an institutional bar to the court considering whether section 2 of the 1961 Act satisfies those requirements of proportionality because the legality of assisted suicide is a matter which falls within the UK's wide margin of appreciation and Parliament has given its decision on the matter in the 1961 Act. It is accepted by the SoS that, in principle, the court has jurisdiction to consider whether section 2 of the 1961 Act is compatible with Article 8 because that is part of the court's function as determined by Parliament under the HRA.

126. The SoS does, however, contend, by the respondent's notice, that the court is bound by the decision of the House of Lords in *Pretty*, as a matter of precedent, to hold that section 2 of the 1961 Act meets the conditions in Article 8(2) and is, therefore, compatible with Article 8. We reject that submission. We do not do so on the basis that, as contended by Ms Lieven, *Pretty* was a case about euthanasia rather than assisted suicide. We consider it is clear that the House of Lords dealt with the case as one of assisted suicide: see the judgment of Lord Steyn at [44]. We do so for two reasons. First, as the Divisional Court noted (at [81]-[82]), no Justice of the Supreme Court in *Nicklinson* suggested that the decision in *Pretty* had binding precedential effect on a domestic *Re G* application of Article 8(2), subject only to the Supreme Court's inherent power to depart from previous decisions of itself and the House of Lords. They plainly considered the matter to be at large. Secondly, the balancing exercise under Article 8(2) falls to be carried out on the facts as they exist at the moment, and in the light of all that has taken place since *Pretty* and the precise scheme that is now put forward and the evidence adduced by the parties, which differs from that before the court in *Pretty*: comp. *Nicklinson* at [174] (Lord Mance).

127. We understand Mr James Eadie QC, for the SoS, to have sought to run a parallel argument that, even when the Court is deciding whether section 2 is proportionate as a matter of domestic law under *Re G*, it is required by the terms of section 2 of the HRA and cases such as *R (Ullah) v Special Adjudicator* [2004] UKHL 26, [2004] 2 AC 323 and *R (Al-Skeini) v Secretary of State for Defence* [2007] UKHL 26, [2008] AC 153, to go no further than what has been decided by the ECtHR; namely that, as determined in *Pretty v United Kingdom*, section 2(1) falls within the United Kingdom's margin of appreciation and the domestic court should go no further.

128. We disagree with those submissions. Mr Eadie's argument is circular in that, on his argument, the domestic court has to make a decision for itself under a domestic *Re G* interpretation because the ECtHR has held the matter to fall within the United Kingdom's margin of appreciation, only for the domestic court to be prevented from doing so by having to take into account the very decision which gives the domestic court latitude to make its own decision.

129. The court must, therefore, consider whether the blanket ban on assisted suicide under section 2 of the 1961 Act is both necessary and proportionate, having regard to the proposed scheme put forward by Mr Conway and the evidence before it. The question for this court is whether the Divisional Court made an error of principle in the way it went about that task for the various reasons advanced by Ms Lieven summarised above. Although, strictly, necessity and proportionality are different requirements and ought to be addressed separately, the relevant considerations and evidence on necessity and proportionality in the present case largely overlap and so in the discussion which follows we do not make this strict distinction.

130. A major feature of the disagreement between the parties is whether the Divisional Court gave too much deference to Parliament's decision incorporated in the 1961 Act and the failure of successive attempts since then to persuade Parliament to change the law on assisted suicide when the matter was debated before it. It is common ground that the respect due to Parliament in this context will depend upon all the circumstances, including the nature of the subject-matter and the extent to which the legislature or judiciary could claim particular expertise or competence: *Countryside Alliance* at [45].

131. As we have said earlier, Ms Lieven's contention is that the court is at least as well placed as Parliament, if not better placed, to decide whether or not the scheme proposed by Mr Conway is viable and effective to protect weak and vulnerable people, and in particular whether the requirement of approval by a High Court judge would provide an adequate procedural safeguard for ensuring that the five substantive criteria in the proposed scheme are satisfied. She emphasised the regular work of the Family Division and of the Court of Protection in assessing mental capacity and, for example, making decisions as to the best interests of patients in withdrawal of treatment cases. Although she did not take us to them, Ms Lieven referred generally in support of those submissions to the comments of Lord Bingham in *A v Secretary of State for the Home Department* [2005] UKHL 71, [2005] 2 AC 68, especially at [38]-[42].

132. On the other hand, Mr Eadie emphasised the respect properly due to Parliament as the democratic decision-maker under our constitutional arrangements on a difficult and contentious area of social policy, whose decision is within the wide margin of appreciation afforded by the ECtHR. He submitted that the question of proportionality on the domestic plane should reflect that wide margin of appreciation at the international level.

133. Another notable feature of the submissions to us is the extent to which both counsel, but particularly Ms Lieven, resorted to an intense analysis of the judgments of the Supreme Court in *Nicklinson*. Although it is plainly appropriate to understand in general terms the reasoning of the Supreme Court in that case, we have not found the dissection of the judgments in that case, alighting on particular sentences or longer

passages that are said to favour one side rather than the other in the present case, particularly enlightening. Ms Lieven sought to extract from some of the judgments, and especially that of Lord Neuberger, support for Mr Conway in speculative thoughts (which Mr Eadie described as "musings") about the prospects of success of a new application for judicial review should Parliament fail to legalise assisted suicide by the Bill then before Parliament and should there be more evidence of a viable scheme than had been presented to the Supreme Court.

134. As will appear from what we say in due course, we have undoubtedly benefited from aspects of the close analysis by members of the Supreme Court in *Nicklinson* of the issues surrounding the legalisation of assisted suicide. The decision in *Nicklinson* is not, however, binding on us as it focused on the situation of people in long term suffering rather than, as under Mr Conway's scheme, those suffering from a terminal illness who are within six months of death. None of the claimants in *Nicklinson* was terminally ill. In the case of two of the claimants in *Nicklinson*, they were so disabled as to be unable to carry out any act themselves to commit suicide, even with assistance from others. Further, while there was only limited evidence in *Nicklinson* as to how weak and vulnerable people might be protected if assisted suicide was legalised, Mr Conway's scheme is specifically designed to impose appropriate safeguards and considerable evidence has been adduced as to whether the proposed scheme would maintain a proper balance between the interests of the cohort of persons in the same position as Mr Conway, on the one hand, and the rest of the community, on the other hand. Moreover, the judgments of the Justices in *Nicklinson* differ to a greater or lesser extent in their detailed reasoning in many significant respects. Beyond the fact that, leaving aside the dissenters, a majority of the other Justices were decisively influenced by the circumstance that Lord Falconer's Bill was then currently before Parliament, and the fact that an overwhelming majority of the Justices thought that in principle Parliament was a better forum for determining the issue of legalising assisted suicide than the courts, it is difficult to pinpoint any other matter decided by the majority which would have a compelling impact on our decision.

Mr Conway's proposed scheme

135. We do not accept Ms Lieven's starting point that the issue under Article 8(2) in the present case is focused solely on the legitimate aim of the protection of weak and vulnerable people. While that is a critical issue in evaluating the suitability and efficacy of Mr Conway's proposed scheme, a decision to permit assisted suicide raises important moral and ethical issues, on which society is divided and many people hold passionate but opposing views.

136. Drawing on Hoffmann LJ's impressive exposition in the Court of Appeal in *Bland* in the passage quoted above, permitting assisted suicide is a statement about the way in which, as a society, we draw the line between two important but, on this issue, competing values: the concept of the sanctity of life, reflected in Article 2 of the Convention, and the right to personal autonomy in choosing the time and manner of our death, protected by Article 8.

137. Lord Steyn graphically expressed the controversial nature of this issue in *Pretty* (at [54]), as follows:

> "The subject of euthanasia and assisted suicide have been deeply controversial long before the adoption of the Universal Declaration of Human Rights in 1948, which was followed two years later by the European Convention on Human Rights and Freedoms (1950). The arguments and counter arguments have ranged widely. There is a conviction that human life is sacred and that the corollary is that euthanasia and assisted suicide are always wrong. This view is supported by the Roman Catholic Church, Islam and other religions. There is also a secular view, shared sometimes by atheists and agnostics, that human life is sacred. On the other side, there are many millions who do not hold these beliefs. For many the personal autonomy of individuals is predominant. They would argue that it is the moral right of individuals to have a say over the time and manner of their death. On the other hand, there are utilitarian arguments to the contrary effect. The terminally ill and those suffering great pain from incurable illnesses are often vulnerable. And not all families, whose interests are at stake, are wholly unselfish and loving. There is a risk that assisted suicide may be abused in the sense that such people may be persuaded that they want to die or that they ought to want to die. Another strand is that, when one knows the genuine wish of a terminally ill patient to die, they should not be forced against their will to endure a life they no longer wish to endure. Such views are countered by those who say it is a slippery slope or the thin end of the wedge. It is also argued that euthanasia and assisted suicide, under medical supervision, will undermine the trust between doctors and patients. It is said that protective safeguards are unworkable. The countervailing contentions of moral philosophers, medical experts and ordinary people are endless. The literature is vast: see for a sample of the range of views: Glanville Williams, The Sanctity of Life and the Criminal Law (1958), ch 8. Ronald Dworkin, Life's Dominion: An Argument About Abortion, Euthanasia and Individual Freedom (1993), ch 7; Euthanasia Examined: Ethical clinical and legal perspectives (1995) essays edited by John Keown; *Margaret Otlowski, Voluntary Euthanasia and the Common Law* (1997), chs 5-8; Mary Warnock, An Intelligent Person's Guide to Ethics (1998), ch 1. It is not for us, in this case, to express a view on these arguments. But it is of great importance to note that these are ancient questions on which millions in the past have taken diametrically opposite views and still do."

138. The moral and ethical dilemma of permitting assisted suicide was recognised in *Nicklinson*. Lord Neuberger, for example, said (at [116]) that "the question whether the provisions of section 2 should be modified raises a difficult, controversial and sensitive issue, with moral and religious dimensions". Lord Mance said (at [190]) that he would adapt to the context of assisted suicide the thought of Rehnquist CJ, expressed in a slightly different context in *Washington v Glucksberg* 521 US 702

(1997), 735, that there is currently "an earnest and profound debate about the morality, legality, and practicality of … assisted suicide".

139. The moral and ethical issues that arise when the principle of sanctity of life rubs up against the principle of personal autonomy are not only to be found in the issue of the ban against assisted suicide and euthanasia. They are also reflected in the drawing of the line between when consent is and is not a defence to wounding or the infliction of actual bodily harm or grievous bodily harm contrary to sections 18 and 20 of the Offences Against the Person Act 1861: *R v Brown* [1994] 1 AC 212, *R v BM* [2008] EWCA Crim 560, especially at [41] and [44]. Here, again, our law has imposed a limit on personal autonomy to reflect wider moral, ethical and practical issues which include, but are not limited to, the protection of the weak and vulnerable.

140. The evidence and submissions of Humanists UK raise all kinds of ethical arguments.

141. Controversy is not restricted to moral and ethical issues. It also surrounds the efficacy of Mr Conway's proposed scheme to protect the weak and vulnerable. Mr Conway's case, as presented in the submissions of Ms Lieven we have recorded earlier, is that consideration of mental capacity and freedom from coercion and undue influence are already familiar in both a legal and professional context as they reflect the considerations in the DPP's Policy and the matters to be taken into account by practitioners under the Guidance issued by the APM and are matters which are routinely the subject of decision by judges of the Court of Protection and the Family Division, as they were in *Re Z*. It is said, on Mr Conway's behalf, that a High Court Judge, adopting an inquisitorial approach, would be well able to form a view as to whether the five substantive criteria are satisfied in a particular case.

142. Voluminous evidence has been adduced as to the appropriateness and efficacy of the substantive criteria in Mr Conway's proposed scheme. There is a dispute on the evidence as to the possibility of predicting death within six months with any reliable degree of accuracy. In her expert report, on behalf of the SoS, Professor Finlay said that she had seen prognostic errors frequently, both where patients have outlived a timespan they were told, and where patients were given an over-optimistic prognosis making it difficult for the bereaved to comprehend the death. She gave examples of such prognostic errors. She said that MND poses particular challenges as regards prognosis, and referred in that context to the views and work of Professor Nigel Leigh, a professor of neurology. She said that, even with the best modelling data available, it is not possible to predict with any reasonable accuracy whether a person with MND will live less than six months. She said that, in other clinical conditions that could be considered terminal, prognosticating is even more difficult.

143. Professor Robert George, a professor and consultant physician in palliative care, has written an expert report on behalf of CNK, in which he has given evidence of error in the medically certified cause of death in 16%-20% of cases. He has also said that individual prognostication, even in diseases such as cancer, is at best an estimate: in patients with multiple and potentially fatal co-morbidities prognosis is altogether unstable, and uncertainty for all diagnoses continues even to the last days of life.

144. The BMA Report stated that there are currently a number of prognostic tools that have been developed that may improve the accuracy of predicting survival of terminally ill patients but there are a number of common limitations associated with them in

relation to the prognostic accuracy of survival at six months or less. It stated that there is no tool currently available that can provide an accurate estimate of survival throughout the spectrum of advanced illness; there are some tools that may improve prognostic accuracy when the actual survival time of an individual is at less than two months but there is still a considerable error and inadequate validation associated with many of those tools. It said that this means that the reliability of these tools accurately to predict survival time across different patient populations, care settings and clinicians is unknown.

145. A public briefing by the APM on its position on assisted suicide of July 2015 ("the APM Report") stated that prognostication, even with the full medical facts, is very unreliable and referred to data from the experience of assisted suicide in Oregon to that effect.

146. The Association of British Neurologists ("the ABN") stated in a report in April 2015 on the conclusions of its working party on assisted dying ("the ABN Report):

> "… not every clinical diagnosis is invariably secure. The nature of neurological illness involves additional uncertainty relating to the course of that illness and future availability of effective treatments. Prognostication is notoriously fallible especially when offered early in the course of a neurological illness that may run a protracted and unreliable clinical course over several years."

147. In her witness statement dated 10 July 2017 Baroness Jane Campbell, who is a founder member of NDYUK, and has a severe form of Spinal Muscular Atrophy, which requires her to use a ventilator at night and for increasing periods during the day and to be fed through a tube, said that she is an example of how the medical profession cannot accurately predict how a medical condition will affect an individual. She said that when she was one year old her mother was told that she would have no more than a year to live. She said that she quite frequently becomes ill with serious chest infections and on one occasion, many years ago, in the local hospital the doctor told her husband (and her) that he thought it was "time to let her go".

148. Even the expert evidence of Professor Barnes, for Mr Conway, is highly qualified on the accuracy of predictions of death within six months. He said it is a very difficult question to answer whether it is possible to predict death within six months and it really depends on the required certainty of that prediction. In his view, such a prediction is possible on the balance of probabilities if certain specific criteria apply to a diagnosis of MND/ALS/fronto-temporal dementia or "classic" MND/ALS. He said that, in other circumstances, such as dealing with an individual with different sub- types of MND/ALS or for individuals who have already lived beyond the expected period of survival, prognostication becomes very difficult and much less certain, even on the balance of probabilities. He expressed no view about the accuracy of prognostication for other illnesses and conditions. He said, in conclusion, that he hoped he had indicated the real difficulty in determining a prognosis of six months or less of remaining life expectation but he considered that, on the balance of probabilities, it is a judgement that can be made in certain specific circumstances.

149. Mr Conway is himself an example of the difficulty of accurate prediction. He was diagnosed in November 2014 with MND, which he probably contracted in about 2012. The average life expectation of a person with MND is between two and five years. Mr Conway is still alive (happily doing far better than the original prognosis expressed in this case): he attended the first afternoon of the appeal hearing via video link from his local court venue.

150. There is a dispute on the evidence as to whether changing the law to permit assisted suicide would have an adverse effect on the doctor-patient relationship, with the BMA Report stating that a majority of the doctors participating in the research were of the view that it would have a negative effect. The APM Report stated that one of the most common concerns of its members was that permitting assisted suicide would have an adverse effect on the doctor-patient relationship. Professor Finlay has also given evidence of the potential adverse impact on the doctor-patient relationship.

151. There is a dispute on the evidence as to the extent to which permitting assisted suicide would result in "doctor-shopping" by a patient. The BMA Report recorded, for example, that many doctors did not see being involved with physician-assisted dying as compatible with their understanding of their fundamental role and remit as a doctor, and expressed a feeling that it could divide the profession and both prompt people to leave the profession and discourage some from entering it. A similar concern on the part of members of the Royal College of General Practitioners ("the RCGP") was recorded in the RCGP's report in January 2014 on its consultation on the College's position on the law on assisted dying ("the RCGP Report"). Professor Finlay's evidence was that, in view of medical opposition to legalisation of assisted suicide, only a small minority of doctors could be expected to participate in any legalised regime. She said that had apparently proved to be the case in Oregon where evidence suggests that "doctor shopping" and supply of lethal drugs by frequent-prescribers are occurring. This would have implications for any inquisitorial investigation by the court since the doctor supporting the decision to undertake assisted suicide might only have known the patient for a relatively short time and might lack a sufficiently detached medical view of the patient's mental and physical condition and the reasons for the patient's decision to commit suicide. We refer to this further below in the context of the adequacy of the proposed inquisitorial process before a High Court judge.

152. It is clear is that there is a significant preponderance of medical opinion against the proposed change. The BMA Report included the following statement under the heading "Policies of doctors' organisations":

> "… With the exception of the Royal College of Psychiatrists, which is neutral, all organisations with policy on the issue are opposed to all forms of assisted dying, while also acknowledging that there are a range of different views within their respective memberships …
>
> The BMA has consistently opposed all forms of assisted dying, with the exception of 2005 when the policy changed to neutral before subsequently reverting back to opposition the following year. The Association's policy is made at its Annual

> Representative Meeting … and current policy dates back to 2006 and states that the BMA:
>
> - Believes that the ongoing improvement in palliative care allows patients to die with dignity.
>
> - Insists that the physician -assisted suicide should not be made legal in the UK. …"

153. The BMA Report identified complications with physician-assisted suicide in a significant number of cases in the Netherlands and in Oregon. In the Netherlands this had caused doctors to prefer to undertake euthanasia rather than assisted suicide.

154. The RCGP Report recorded that 77% of members who submitted response forms directly to the College (234 people) indicated that they felt the College should maintain its negative position to a change in the law, with only 5% supporting a move to a position of being in favour of a change in the law.

155. The APM Report stated that it remained overwhelmingly opposed to a change in the law on assisted suicide as proposed by the Bills then before Parliament.

156. A report of the British Geriatrics Society's position on physician-assisted suicide dated 10 July 2015 ("the BGS Report") stated that "a policy which allows physicians to assist patients to die is not acceptable to us". It also stated that "BGS believes that crossing the boundary between acknowledging that death is inevitable and taking active steps to assist the patient to die changes fundamentally the role of the physician, changes the doctor-patient relationship and changes the role of medicine in society".

157. In a published statement on physician-assisted suicide of 30 April 2005 the World Medical Association ("the WMA") stated that:

> "physician-assisted suicide, like euthanasia, is unethical and must be condemned by the medical profession. Where the assistance of the physician is intentionally and deliberately directed at enabling an individual to end his or her own life, the physician acts unethically. However the right to decline medical treatment as a basic right of the patient and the physician does not act unethically even if respecting such a wish results in the death of the patient".

158. In January 2011 the ABN approved, by a substantial majority, the conclusions of a working group that, in the context of severe disability and a neurological condition likely to prove fatal, administering medication with the intention of providing symptomatic relief, even if this has the secondary effect of shortening life, is consistent with good medical practice, but interventions should not be given with the primary purpose of causing death. A statement of the ABN published in April 2011, having quoted the Hippocratic Oath, said that the working group considered that the crucial issue was the difference between active engagement in the process of dying and deliberately bringing forward that inevitable event.

159. Scope, a national disability charity that campaigns to challenge and change negative attitudes about disability, has also issued a statement that it is opposed to a change in the law on assisted dying.

160. There is evidence of the potential for indirect coercion or undue influence if assisted suicide is permitted. This was a matter particularly emphasised by Ms Catherine Casserley, counsel for NDYUK, and Mr David Lawson, counsel for CNK. The RCGP Report, for example, expressed concern that the "right to die" could very easily become a "duty to die", especially when financial considerations were a factor and the individual felt like a burden to their family. The APM Report said that coercion, real or imagined, may be undetectable and feeling burdensome is a prominent and rising reason for requesting assisted suicide. It also observed that a sense of being a burden can be felt or projected subconsciously and then expressed by either the person or their carer as a genuinely felt belief about the state of affairs.

161. In her expert report Professor Finlay referred to subtle coercion which can arise from a sense of guilt at the cost that illness is imposing on family in terms of money and time. She described societal coercion when assisted suicide is normalised because there is a societal expectation that assisted suicide should be considered by a patient who develops a life-threatening illness. She also referred to the work of Dr Madelyn Hicks, a psychiatrist, who has reviewed the implications of physician-assisted suicide for UK doctors, and has shown that coercion and unconscious motivations on the part of patients and doctors in the form of transference and counter transference contribute to the misapplication of physician-assisted suicide, and which is difficult to recognise. There is disagreement as to the meaning and significance of Professor Finlay's comments in paragraphs 90 and 91 of her expert report that, if judges of the Family Division were involved in reviewing requests for assisted suicide, that would allay her concern of doctor-shopping and would avoid the transference/counter transference difficulties she had mentioned. What is clear, however, is that the Family Division procedure she mentioned was one in which evidence is obtained and tested from the various interests involved, including doctors, mental health professionals, social workers, family and the applicants themselves. It is not straightforward to see how the proposed inquisitorial procedure for Mr Conway's scheme would ensure a proper testing of the evidence; and indeed Ms Lieven accepted that it might well not be possible to identify indirect social coercion.

162. Dr Hicks' work is also mentioned in the expert report of Professor George. He stated that coercion is very subtle, from overt pressure and malicious encouragement, through subtle suggestion (not necessarily malicious but deriving from, for example, care fatigue), to internalised misplaced feelings by the patient of being a burden on the family. He said that detecting coercion depends crucially on the relationship and a working knowledge of a person's family or forensic objectivity, a characteristic that is not routinely part of doctors' training. That is a problem that would be accentuated if a significant number of doctors refused to engage with assisted suicide and significant doctor-shopping resulted.

163. In *Pretty* (at [30]) Lord Bingham said that it is not hard to imagine that an elderly person, in the absence of any pressure, might opt for a premature end to life if that were available, not from a desire to die or a willingness to stop living, but from a desire to stop being a burden to others.

164. Ms Lieven challenged the significance and weight to be attached to such evidence. As we have mentioned earlier, she said, for example, that the opposition of medical bodies proceeds very much from the perspective of the participation of their members rather than the benefit to the patients, and she placed emphasis on the finding of BMA's research that the members of the public who participated had a "largely balanced range of potential positive and negative impacts".

165. She played down the significance of the RCGP Report, a report by the Royal College of Physicians (which was not mentioned by Mr Eadie in his oral submissions) and the BGS Report because, in the case of the first two, they do not address the question of the precise role that doctors would play in the process and, in the case of all three, they do not address the potential role of the High Court.

166. She said that the APM Report, if analysed carefully, is much more nuanced than might otherwise appear and drew particular attention to the following statement which it contains:

> "[w]ere the law to change, and protagonists and legislators truly focussed on protecting the newly vulnerable, moving executive authority and responsibility from medicine to an appropriate judicial process with specialist non-technical technicians will be less harmful and more transparent."

167. So far as concerns the stated views of the WMA, Ms Lieven observed that medical associations in countries where assisted dying (or euthanasia) are legal are members of the WMA and so presumably do not consider themselves bound by the WMA's statement on assisted suicide and euthanasia; and, moreover, the doctors in such countries must be complying with the relevant codes of medical ethics that govern them.

168. In relation to the ABN, Ms Lieven's submissions left the evidential position in a particularly unsatisfactory state of uncertainty. In her reply submissions on the afternoon of the last day of the appeal hearing, she stated that, upon further investigation, the ABN statement of 2011 does not represent the current position and referred to an undated statement on ABN's website which stated that the "2011 statement is out of date and is replaced by the RCP 2014 survey … The ABN will work with the RCP on its planned review of this study in 2019". That undated statement is not in evidence and so Mr Eadie was not in a position to comment on it.

169. She referred to a blog from the Royal College of Psychiatrists website from 2014 which makes clear that the College's position is one of neutrality on the basis that the decision whether to legalise physician-assisted suicide should be a matter for Parliament. She observed that the blog does not make any reference to the potential impact on doctor-patient relationships.

170. Ms Lieven referred to the witness statement of Sir Graeme Catto, the former President and then Chair of the General Medical Council from 2002-2009, who said that: "If dying was permitted within a legal framework, I do not think that it would present problems with developing a new approach to regulation".

171. Despite Ms Lieven's submissions on the evidence, what remains quite clear is that an element of risk will inevitably remain in assessing whether an applicant has met the criteria under Mr Conway's proposed scheme. The submissions and counter-submissions of counsel on the evidence, limited as it is to the evidence which the parties choose to place before the court, highlight the limitation of the ability of the court to assess with confidence the precise extent of the risk. The weight to be given to that risk, in deciding whether or not the blanket ban on assisted suicide is both necessary and proportionate, involves an evaluative judgement and a policy decision, which, for the reasons we give below, Parliament is, on the face of it, better placed than the court to make.

172. There are other concerns.

173. The BMA Report refers to documented cases in Holland and Oregon of problems with carrying out assisted suicide. It said that a 2000 review analysed problems with administration in 649 cases of euthanasia and assisted suicide in the Netherlands. In 114 cases the physician's intention was to provide assistance with suicide. Complications arose in 7% of those cases, and problems with completion (e.g. a longer than expected time to death; failure to induce a coma; induction of a coma followed by awakening of the patient) occurred in 16 per cent of cases. It referred also to complications in a number of cases in Oregon, and described the types of complications that could occur with assisted suicide as including regurgitation of medication, vomiting, seizures and muscle spasms. There was no challenge by Ms Lieven to those facts.

174. Another concern is whether and how the proposed inquisitorial role of a High Court judge would work in practice. The judge would only be able to assess such matters as freedom from coercion or direct or indirect undue influence or the medical assessment of the imminence of death if given the evidential material to do so. This would require some independent person or agency to carry out the appropriate evidential investigation and also, possibly, to play some role in the court hearing. As King LJ observed during the course of the hearing, such an inquisitorial approach would require funding but whether or not such funding would be available is completely unknown. It is not a satisfactory answer to say, as Ms Lieven did, that all of those practical and regulatory details could be worked out by Parliament or the Law Commission if the court made a declaration of incompatibility. Those considerations are relevant as to whether the court is in a position to hold section 2(1) to be incompatible in the first place.

175. Another concern is whether it is likely that others would in due course seek to extend the scheme to different categories, arguing that the exclusion of those different categories is illogical, discriminatory or otherwise unjustified. In Belgium, for example, euthanasia has now been extended to seriously ill children.

176. We agree with Butler-Sloss and Hoffmann LJJ in *Bland* at 823H-824A and 831F that an objectively clear line exists in law and fact at the moment between, on the one hand, an act or omission which allows causes already present in the body to operate and, on the other hand, the introduction of an external agency of death: and see Lord Goff in the House of Lords at 864-866, 868 and 873, and Lord Bingham in *Pretty* at 813E. The evidence of the views of professional medical associations shows that this is a line which their members also find to be clear. It is a concern that, if the clear line

which currently exists between suicide, on the one hand, and assisted suicide and euthanasia, on the other hand, is moved by the legalisation of assisted suicide, it might make the different legal treatment of assisted suicide and euthanasia very difficult to maintain. This is a problem which emerges clearly from the evidence of Professor Finlay, Professor George and the APM Report.

177. Another matter to be placed in the balance is the advance made in palliative care in recent years. There is expert evidence from Professor Christina Faull, a palliative medicine consultant, and Professor George as to the ability of modern palliative medicine better to assist those suffering from MND towards the end of their life, and in particular to prevent and manage breathlessness and distress, including when the time comes for NIV to be withdrawn.

178. All those matters raise wide-ranging policy issues.

179. It is the responsibility of the courts under the HRA to determine whether or not there has been infringement of the Convention, and in many cases that involves the court itself reaching a decision on matters which have wide ranging implications for society. In the case of qualified Convention rights, such as Article 8, the court is required to weigh the interests of the wider community against the interests of the individual applicant. It is well established, however, that in some cases it is appropriate to give respect to the views of the executive or of Parliament. How much respect should be given will depend upon all the circumstances.

180. In withdrawal of treatment cases, such as *Bland* and *Briggs*, where the court is dealing with common law rights, that is the absolute right to refuse or terminate medical treatment even if it is necessary to keep a person alive, and Parliament has not intervened and is not proposing to intervene in relation to them, the court has had no option but to tackle difficult moral, ethical and social considerations in order to reach a decision. The same is true of cases like that of the conjoined twins in *Re A*. In such cases the court is applying well established common law or statutory principles to new situations, in particular determining what is in the best interests of a person, or a child, who is legally unable to determine the matter for himself or herself.

181. That is not the position here. There is no common law right to assisted suicide and Parliament has expressed a clear position, not only by the terms of the 1961 Act itself, but by subsequently and relatively recently rejecting legislation along the lines of Mr Conway's scheme. What is in issue is not the application of well established principles to new facts but the possible legalisation of conduct that was criminal at common law and is now criminal as a matter of statute.

182. It is not necessarily a sufficient answer to say, as Ms Lieven does, that doctors are already applying under BMA guidelines precisely the same checks as would be done under Mr Conway's proposed scheme when satisfying themselves in a withdrawal of treatment case that the patient's decision is made with mental capacity, free from coercion and undue influence, is settled and is based on a clear rationale with knowledge of alternatives. The doctors in such a case have to do the best they can in the circumstances because it is the common law right of the patient to insist on withdrawal of treatment.

183. Similarly, it is not sufficient answer to say, as Ms Lieven does, that it is well established, in withdrawal of treatment cases, that a capacitous person exercising their common law right to prevent physical interference to themselves is entitled to make what others might consider to be a bad decision. The concerns as to legalising the assistance of suicide relate to concerns as to assessing capacity, coercion, undue influence and the other matters we have mentioned; not to the wisdom of the ultimate decision.

184. Nor is it right to sweep aside all the concerns about the impact of legalisation of assisted suicide and the way Mr Conway's scheme would operate by reference to the fact that assisted suicide is legal in some other jurisdictions. We were referred to evidence of arrangements for assisted suicide in Oregon, Canada, the Netherlands and Belgium. The arrangements in each of them are different. Some are statutory and some are not. No doubt they reflect the priorities in values and the compromises which are deemed appropriate in those particular countries. They are of interest and no doubt of varying degrees of relevance to the debate about assisted suicide in this jurisdiction but they can hardly carry any decisive weight in a court here, and certainly not on the limited state of the evidence before us.

185. When considering whether the blanket ban is necessary and proportionate, the DPP's Policy is also a relevant consideration. The evidence is that this has been faithfully implemented and so provides a reasonable degree of assurance on likely prosecution. In a speech on "Assisted Dying" on 8 September 2016 Sir Keir Starmer QC MP, the former DPP, said that in his five years as DPP, of the 80 or so assisted suicide cases, there was only one prosecution – of someone who provided petrol and a lighter to a vulnerable man known to have suicidal intent, who subsequently suffered severe burns as a result. In the BMA Report it was stated that, as of October 2015, since the publication of the DPP's policy, there had been 117 cases of assisted suicide referred to the CPS by the police but only one successful prosecution in October 2013; and that case had involved neither a medical professional nor a victim with a medical condition. In other words, in the context of the circumstances which Mr Conway postulates in the criteria which have been advanced to the court, although we recognise that a retrospective examination of events in the context of the DPP's policy will always be more traumatic and difficult, the possibility of prosecution is not a high risk.

186. There can be no doubt that Parliament is a far better body for determining the difficult policy issue in relation to assisted suicide in view of the conflicting, and highly contested, views within our society on the ethical and moral issues and the risks and potential consequences of a change in the law and the implementation of a scheme such as that proposed by Mr Conway. The contentious nature of the proposal is reflected in the fact that assisted suicide is unlawful in the great majority of Convention countries. It is particularly of note that Mr Conway's proposed scheme is broadly equivalent to the Falconer Bill, which never became law, and the Marris Bill, which was rejected by the House of Commons. It is also particularly of note that the Select Committee which examined the Joffe Bill, consulted and received wide ranging evidence from a large number of organisations and individuals on the issues which have been the subject of debate in the present proceedings and extending well beyond the evidence in the present case, visited three foreign jurisdictions which permitted

assisted suicide, namely Oregon in the USA, the Netherlands and Switzerland, and invited Parliament to debate its report.

187. That is why we do not consider apt Ms Lieven's submission comparing the safeguards in the proposed scheme adversely with those for ADRTs. ADRTs are not a construct of the court but are governed by statute determined by Parliament. Further, they are made by a person who has capacity and who chooses to specify the treatment or continuation of treatment at a later time when he or she lacks capacity (section 24 of the MCA). A person can withdraw their advance decision orally at any time and, where there is any doubt as to the applicability of an advance decision, the matter can be brought to court as a matter of urgency. It follows that ADRTs are a statutory vehicle enabling a person to determine, in advance, the circumstances in which he or she would wish to exercise his or her common law right to have treatment withdrawn and are not therefore comparable with assisted suicide.

188. Furthermore, the court is restricted to considering the suitability of the precise scheme proposed by Mr Conway, who has chosen to limit it to those suffering terminal illness within six months of death. We are not in a position to say whether, if there are adequate protections which show that a blanket ban on assisted suicide is not necessary and proportionate, the line should be drawn elsewhere, such as those who are within 12 months of death.

189. As we have said, the evidence in this case is considerable. Important parts of it are conflicting. There was no request for oral evidence or cross-examination. That seems to us to be right. The conflict inherent in the moral and ethical issues involved in balancing the principles of sanctity of life and the right of personal autonomy cannot be resolved in a forensic setting by cross-examination. Conflicts in the expert opinion and factual evidence as to the appropriateness of the criteria in Mr Conway's scheme and the existence and extent of risk of an incorrect decision that the substantive criteria are satisfied are unlikely to be resolved satisfactorily by cross-examination. Furthermore, the evidence available to the court is necessarily limited to that which the parties wish to adduce. Unlike Parliament, or indeed the Law Commission of England and Wales, the court cannot conduct consultations with the public or any sector of it and cannot engage experts and advisers on its own account.

190. In *Pretty* Lord Steyn said (at [57]):

> "In our Parliamentary democracy, and I apprehend in many member states of the Council of Europe, such a fundamental change cannot be brought about by judicial creativity. If it is to be considered at all, it requires a detailed and effective regulatory proposal. In these circumstances it is difficult to see how a process of interpretation of Convention rights can yield a result with all the necessary inbuilt protections. Essentially, it must be a matter for democratic debate and decision-making by legislatures."

191. In *Nicklinson* the virtually unanimous view of the Justices was that Parliament was, in the circumstances, a more appropriate forum than the courts for resolving the issue of assisted suicide in that case: see Lord Neuberger at [116], Lord Mance at [164], [166]-

[168], [190], Lord Wilson at [197], Lord Sumption at [230]-[232], Lord Hughes at [267], Lord Clarke at [293], Lord Reed at [296]-[297], and Baroness Hale at [300].

192. Furthermore, in *Nicklinson v United Kingdom* the ECtHR rejected as manifestly ill-founded the application of Mrs Nicklinson that the domestic courts had violated the Convention rights of herself and Mr Nicklinson by refusing to determine the compatibility of section 2(1) of the 1961 Act with their Article 8 rights. The Court said, with regard to the decision of the majority of the SCJJ in *Pretty*:

> "The fact that in making their assessment they attached great significance … or "very considerable weight" to the views of Parliament does not mean that they failed to carry out any balancing exercise. Rather, they chose – as they were entitled to do in the light of the sensitive issue at stake and the absence of any consensus among Contracting States – to conclude that the views of Parliament weighed heavily in the balance."

193. Weighing the views of Parliament heavily in the balance in a case such as the present one is not the same as a complete abdication of responsibility to consider the merits of the arguments on either side in relation to Article 8(2).

194. After the completion of oral submissions on this appeal the Supreme Court handed down judgments in *In the matter of an application by the Northern Ireland Human Rights Commission for judicial review (Northern Ireland)* [2018] UKSC 27 ("the Northern Ireland case"). The parties have made further written submissions on the significance of those judgments for this appeal.

195. The Supreme Court were concerned in the Northern Ireland case with a challenge to the compatibility of sections 58 and 59 of the Offences Against the Person Act 1861 and section 25(1) of the Criminal Justice Act (NI) 1945, which criminalise abortion in Northern Ireland, with Articles 3 and 8 of the Convention. A majority of the Supreme Court (Lord Mance, Lord Reed, Lady Black and Lord Lloyd-Jones) held that the Northern Ireland Human Rights Commission did not have standing to bring those proceedings and that, accordingly, the Court had no jurisdiction to make a declaration of incompatibility under section 4 of the HRA. Focusing on the Article 8 claims for present purposes, a majority (Lord Mance, Lord Kerr, Lord Wilson and Lady Hale) decided that, had they had jurisdiction, they would have held the current law incompatible with Article 8, insofar as it prohibits abortion in cases of rape, incest and fatal foetal abnormality, whilst Lady Black agreed to the extent that the law prohibits abortion in the case of fatal foetal abnormality.

196. There is nothing in those judgments which causes us to change our conclusion as to the outcome of the present case. The Supreme Court in the Northern Ireland case confirmed the point we make above that, where the ECtHR has held an issue to fall within a state's margin of appreciation, the approach in *Re G* is of general application (see Lady Hale at [38] and Lord Mance at [115]-[116]). The breadth of the discretionary area of judgment accorded to Parliament when undertaking a *Re G* exercise will vary depending on the context and the extent to which the principles of relative institutional competence and democratic accountability are engaged by a particular case. The issue in the present case is different from the issue before the Supreme Court in the Northern Ireland case for the following reasons.

197. First, in that case the majority considered that abortion was a matter on which the courts are as well qualified to judge as the legislature, if not better qualified (see Lady Hale at [38] and Lord Kerr at [298]). By contrast, in the present case, as we have already made clear, there is a great deal of conflicting evidence as to the consequences of legalising assisted dying about which reasonable people clearly do reasonably disagree and which the court, by contrast with Parliament, is not well placed to assess. We have described those difficulties in paragraph [189] above.

198. Secondly, the Supreme Court distinguished the issues in that case and in *Nicklinson*, and therefore, by extension, distinguished the issues in the present case. As Lord Kerr appears to have suggested (at [298]), the issue of assisted dying is more difficult, controversial and sensitive in terms of its moral and religious dimensions and therefore harder to identify and to cure. Lady Hale (at [40]) also noted that the issues in *Nicklinson* were "not as clear cut". A key reason for this was identified by Lord Mance as follows:

> "118. *Nicklinson* was also a different case from the present in significant respects. First, it centred on a difficult balancing exercise between the interests of different adult persons: on the one hand, the sufferer with locked-in syndrome, unable to act autonomously, but unable to receive assistance to commit suicide; on the other hand, the others, elderly or infirm, who might feel pressured by others or by themselves to commit suicide, if assistance were permissible. The balancing of autonomy and suffering against the risks to others was and is a particularly sensitive matter. The legislature had chosen an absolute protection against the latter risks, with which the courts should not, at least at that juncture, interfere.
>
> On the present appeal, there is in law no question of a balance being struck between the interests of two different living persons. The unborn foetus is not in law a person, although its potential must be respected. In addition, the current legislation already recognises important limitations on the interests and protection of the unborn foetus. It permits abortion of a healthy foetus in circumstances where the mother's life would be at risk or where she would suffer serious long-term damage to her physical or psychological health. There is therefore no question of any absolute protection of even a healthy foetus. …"

199. Thirdly, Lord Mance noted (at [120]) that the United Kingdom's approach to assisted dying reflected a similar approach across almost the whole of the rest of Europe, whereas the abortion laws of Northern Ireland were almost alone in their strictness.

200. Finally, the concern of the Supreme Court in relation to abortion in Northern Ireland was that there was no assurance as to when the Northern Ireland Assembly would address the issue, or whether they would even address the issue at all (Lord Mance at [117]). By contrast, as we have noted above, Parliament has actively considered assisted dying on several occasions both before and after *Nicklinson* and has given no indication it would not be prepared to do so again.

The reasoning of the Divisional Court

201. We can find no error of principle in the reasoning of the Divisional Court. They observed (at [47]) that, in these proceedings, the SoS contends that a number of

objectives are promoted by section 2 of the 1961 Act, not limited to protection of the weak and vulnerable, but including also respect for the sanctity of life and promotion of trust between patient and doctor in the care relationship.

202. The Divisional Court examined the various occasions on which the prohibition of assisted suicide has been discussed in Parliament since enactment of section 2 of the 1961 Act. They considered the position in foreign jurisdictions and the evidence of the views of medical associations. They considered the evidence of Scope and expert evidence.

203. The Divisional Court concluded (at [68] and [94]) that there is a real risk that a change in the law to legalise provision of assistance for suicide would have a serious detrimental effect on trust between doctors and patients. They concluded (at [96]) that there is a rational connection between the prohibition in section 2 of the 1961 Act and the protection of the weak and vulnerable. They also were of the view (in [97]) that the prohibition serves to reinforce a moral view regarding the sanctity of life and serves to promote relations of full trust and confidence between doctors and their patients. They rejected the submission, on behalf of Mr Conway, that the proposed scheme would be adequate to address concerns regarding the protection of the weak and vulnerable, let alone the other legitimate aims of the blanket prohibition in section 2 of the 1961 Act.

204. Ms Lieven has criticised the failure of the Divisional Court to set out in a fair way all the arguments and evidence pointing to different conclusions. We do not consider that the Divisional Court was under an obligation to set out in meticulous detail all the evidence before them. More to the point, in the light of the matters to which the Divisional Court did refer, and to which we have referred above, we consider that it is impossible to say that the Divisional Court did not have material on which properly to come to their conclusions on the inadequacy of the proposed scheme to protect the weak and vulnerable, on the scheme's failure to give proper weight to the moral significance of the sanctity of life and on the scheme's potential to undermine relations of trust and confidence between doctors and their patients.

205. The Divisional Court said (at [106]) that an evaluative judgement is required, and has been made by Parliament, in making an assessment of how people would behave and how society might be affected if section 2 of the 1961 Act were amended and whether the blanket prohibition in section 2 is necessary to protect the weak and vulnerable. They said that the evidence shows that there is a serious objective foundation for Parliament's assessment of that matter. They explained (at [109]) why, in the circumstances, there are powerful constitutional reasons for the court to respect Parliament's assessment of the necessity of maintaining section 2 and (at [110]) why Parliament is better placed than the court to make the relevant assessment regarding the likely impact of changing the law. They said (at [112]-[113]) that the respect due to Parliament's assessment is even stronger in relation to the moral issues and the promotion of trust between doctor and patient. That approach was plainly not an abdication of all responsibility to make an assessment under Article 8(2). It was according appropriate respect for the views of Parliament when carrying out the assessment under Article 8(2).

206. For much the same reasons, the Divisional Court concluded (at [114]) that the prohibition in section 2 of the 1961 Act achieves a fair balance between the interests of the wider community and the interests of people in the position of Mr Conway.

207. In the light of what we have said above, we do not consider that the approach or those conclusions of the Divisional Court can be faulted.

Conclusion

208. For the reasons we have set out above, we dismiss both the appeal and the respondent's notice.