ORDER PROHIBITING PUBLICATION OF THIS JUDGMENT UNTIL 3.00PM ON 5 JUNE 2015.

IN THE HIGH COURT OF NEW ZEALAND
WELLINGTON REGISTRY

CIV-2015-485-000235
[2015] NZHC 1239

UNDER	The Declaratory Judgments Act 1908 and the New Zealand Bill of Rights Act 1990
BETWEEN	LECRETIA SEALES Plaintiff
AND	ATTORNEY-GENERAL Defendant

Hearing:	25-27 May 2015
Counsel:	A S Butler with C J Curran, C M Marks, M L Campbell and E J Watt for Plaintiff Mr M Heron QC, Solicitor-General with P T Rishworth QC, E J Devine and Y Moinfar for Defendant M S R Palmer QC and J S Hancock for Human Rights Commission V E Casey and M S Smith for Care Alliance K G Davenport QC with A H Brown and L M K E Almoayed for Voluntary Euthanasia Society of New Zealand (Incorporated)
Judgment:	4 June 2015

JUDGMENT OF COLLINS J

Summary of judgment

[1] Ms Seales is dying from a brain tumour.[1] She is 42 years old and may have only a short time to live.[2]

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[1] The names of Ms Seales' principal oncologist, another oncologist who has treated her and her doctor have been suppressed. Affidavit of Ms Seales' principal oncologist, 2 April 2015 at [7]-[8]; Ms Seales' principal oncologist has explained Ms Seales has "diffuse astrocytoma ... with elements of an oligodendroglioma. This combination is often abbreviated to 'oligoastrocytoma'. Both astrocytoma … and oligodendroglioma … grow diffusely and infiltrate the brain".

[2] Second affidavit of Ms Seales' principal oncologist, 22 May 2015 at [6]; Ms Seales can now

[2] Ms Seales wants to have the option of determining when she dies. To do this, Ms Seales would like her doctor to be able to either administer a fatal drug to Ms Seales, or provide Ms Seales with a fatal drug to enable Ms Seales to end her life by herself.

[3] Ms Seales' doctor is willing to take either of these steps, but will not do so unless she can be assured she would be acting lawfully if she acceded to either of Ms Seales' requests.

[4] Ms Seales has sought two declarations concerning the meaning of two provisions of the Crimes Act 1961 (the Crimes Act) to determine whether or not Ms Seales' doctor can lawfully accede to either of Ms Seales' requests.

[5] First, Ms Seales has sought a declaration that her doctor would not commit either murder or manslaughter under s 160(2)(a) and (3) of the Crimes Act if she "administered aid in dying" to Ms Seales.[3] "Administered aid in dying" is defined in the statement of claim to mean:[4]

> … the administration by a medical practitioner, or a person acting under the general supervision of a medical practitioner in the context of a patient/physician relationship, of medication or other treatment that brings about the death of a patient who:
>
> (1) being competent to do so, clearly consents to the administration of that aid; and
>
> (2) is suffering from a grievous and terminal illness that causes enduring suffering that is intolerable to the individual in the circumstances of his or her illness.

[6] Second, Ms Seales has sought a declaration that her doctor would not be assisting her to commit suicide, which is prohibited by s 179(b) of the Crimes Act, if

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expect to live "no more than weeks or a short number of months"..

3 **160 Culpable homicide**
...
(2) Homicide is culpable when it consists in the killing of any person–
(a) By an unlawful act…
...
(3) Except as provided in section 178 of this Act, culpable homicide is either murder or manslaughter.
...

4 Amended Statement of Claim of L Seales, 20 April 2015 at [11] and annexure.

her doctor "facilitated aid in" Ms Seales' dying.[5] "Facilitated aid in dying" is defined in the statement of claim to mean:[6]

> … a medical practitioner, or a person acting under the supervision of a medical practitioner in the context of a patient/physician relationship, making available to a patient the means by which the patient may bring about his or her own death where the patient:
>
> (1) being competent to do so, clearly consents to the provision of that aid; and
>
> (2) is suffering from a grievous and terminal illness that causes enduring suffering that is intolerable to the individual in the circumstances of his or her illness.

[7] I refer to s 160(2)(a) and (3) and s 179(b) of the Crimes Act as "the offence provisions of the Crimes Act", and the declarations Ms Seales seeks relating to the interpretation of those provisions as "the criminal law declarations".

[8] The criminal law declarations sought by Ms Seales are:[7]

> (1) In circumstances where the Court is satisfied that the plaintiff is a competent adult who:
>
> (i) clearly consents to the administered aid in dying; and
>
> (ii) has a grievous and terminal illness that causes enduring suffering that is intolerable to her in the circumstances of her illness, administered aid in dying is not unlawful under section 160 of the Crimes Act.
>
> (2) In circumstances where the Court is satisfied that the plaintiff is a competent adult who:
>
> (i) clearly consents to the facilitated aid in dying; and
>
> (ii) has a grievous and terminal illness that causes enduring suffering that is intolerable to her in the circumstances of her illness, facilitated aid in dying is not prohibited by section 179 of the Crimes Act.

[9] I cannot declare that Ms Seales' doctor would be acting lawfully if she administered a fatal drug to Ms Seales within the terms sought. Nor can I declare

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5 **179 Aiding and abetting suicide**
Every one is liable to imprisonment for a term not exceeding 14 years who–
…
(b) Aids or abets any person in the commission of suicide.

6 Amended Statement of Claim of L Seales, above n 4, at [11] and annexure.

7 At [38].

that it would be lawful for Ms Seales' doctor to provide her with a fatal drug knowing that Ms Seales intended to use that drug to end her own life and did so. Because Ms Seales' health is rapidly deteriorating, I informed the parties of this aspect of my decision on 2 June 2015.[8]

[10] In the alternative, Ms Seales asks that I issue declarations that the offence provisions of the Crimes Act are not consistent with two rights guaranteed by the New Zealand Bill of Rights Act 1990 (the NZBORA). The rights in question are the "right not to be deprived of life"[9] and the right not to be "subjected … to cruel, degrading, or disproportionately severe treatment".[10] I refer to the declarations relating to the application of ss 8 and 9 of the NZBORA as "the Bill of Rights declarations".

[11] The Bill of Rights declarations sought by Ms Seales are:[11]

> (1) Section 160 of the Crimes Act is inconsistent with sections 8 and 9 of BORA, to the extent that administered aid in dying is unlawful under section 160 for a competent adult who:
>
> (i) clearly consents to the administered aid in dying; and
>
> (ii) has a grievous and terminal illness that causes enduring suffering that is intolerable to the individual in the circumstances of his or her illness.
>
> (2) Section 179 of the Crimes Act is inconsistent with sections 8 and 9 of BORA, to the extent that it prohibits facilitated aid in dying for a competent adult who:
>
> (i) clearly consents to the facilitated aid in dying; and
>
> (ii) has a grievous and terminal illness that causes enduring suffering that is intolerable to the individual in the circumstances of his or her illness.

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8 *Seales v Attorney-General* [2015] NZHC 1210.

9 **8 Right not to be deprived of life**
No one shall be deprived of life except on such grounds as are established by law and are consistent with the principles of fundamental justice.

10 **9 Right not to be subjected to torture or cruel treatment**
Everyone has the right not to be subjected to torture or to cruel, degrading, or disproportionately severe treatment or punishment.

11 Amended Statement of Claim of L Seales, above n 4, at [40].

[12] I have decided that Ms Seales' right not to be deprived of life is engaged, but not breached in her case. I have also concluded that Ms Seales' right not to be subjected to cruel, degrading or disproportionately severe treatment is not engaged by her tragic circumstances. I have therefore concluded the relevant provisions of the Crimes Act are consistent with the rights and freedoms contained in the NZBORA.

[13] The criminal law declarations sought by Ms Seales invite me to change the effect of the offence provisions of the Crimes Act. The changes to the law sought by Ms Seales can only be made by Parliament. I would be trespassing on the role of Parliament and departing from the constitutional role of Judges in New Zealand if I were to issue the criminal law declarations sought by Ms Seales.

[14] This judgment has been delivered urgently so Ms Seales can be made aware of my decision while that is still possible.

[15] I have had the benefit of considering evidence from 36 witnesses, who provided 51 affidavits. None were cross-examined. Many of the witnesses reflect the wide spectrum of views that exist in society about the merits of Ms Seales' case. For every proponent of Ms Seales' case, there is an equally forceful opponent.

[16] Ms Seales' proceeding is one of many that have come before the courts in a number of jurisdictions in recent years, in which parties have tested the lawfulness of the role of doctors in bringing about the death of patients. Those cases tend to fall into three categories:

(1) First, cases in which courts have held that it is lawful for doctors to withdraw futile medical services to patients in circumstances where it is known the patient will die without those services.[12]

(2) Second, cases in which it has been held that doctors cannot accede to requests to terminate the life of competent patients who are not

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[12] For example, *Auckland Area Health Board v Attorney-General* [1993] 1 NZLR 235 (HC); *Airedale NHS Trust v Bland* [1993] AC 789 (HL).

terminally ill, but nevertheless wish to die in order to alleviate their suffering.[13]

(3) Third, cases in which competent and terminally ill patients have sought the assistance of their doctors to end their lives in order to avoid intolerable deaths.[14]

[17] The common characteristic to all these cases is that Judges have been asked to determine complex legal issues, sometimes urgently, in a context in which philosophical, moral, ethical and clinical viewpoints are deeply divided. Ms Seales' tragic case is the epitome of this type of proceeding.

[18] To assist in understanding this judgment I have divided it into three parts.

[19] Part I explains the context to the decision I have had to make. It explains Ms Seales' circumstances, her prognosis, her doctor's viewpoint and four relevant principles.

[20] Part II explains the offence provisions of the Crimes Act and why I have concluded that Ms Seales' doctor would risk being prosecuted if she acceded to either of Ms Seales' requests.

[21] Part III explains the rights contained in ss 8 and 9 of the NZBORA and why I have concluded that while the right not to be deprived of life is engaged by the circumstances of Ms Seales' case, that right has not been breached. I also explain why the rights in s 9 of the NZBORA are not engaged in this case.

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13 For example, *R (Nicklinson) v Ministry of Justice* [2014] UKSC 38, [2014] 3 WLR 200.

14 For example, *R (Pretty) v Director of Public Prosecutions (Secretary of State for the Home Department intervening)* [2001] UKHL 61, [2002] 1 AC 800; *Pretty v United Kingdom* [2002] ECHR 427 (Section IV, ECHR); *Carter v Canada (Attorney-General)* [2015] SCC 5; *Fleming v Ireland* [2013] 1 IESC 19; *Morris v Brandenberg* Second Judicial District Court, New Mexico No D-202-CV 2012-02909, 13 January 2014, *Baxter v Montana* 2009 MT 449 (Mont 2009); *Stransham-Ford v Minister of Justice* [2015] ZAGPPHC 230 (HCSA).

PART I

CONTEXT

Ms Seales

[22] When this proceeding was commenced on 20 March 2015 it was estimated Ms Seales could expect to live approximately three to 18 months.[15] Ms Seales' principal oncologist explained, however, that predicting the life expectancy of a person in Ms Seales' circumstances is difficult because brain tumours vary greatly in their rates of growth and impact.

[23] Unfortunately, Ms Seales' condition has deteriorated more rapidly than was anticipated at the time she commenced this proceeding. She is now receiving hospice care. Ms Seales attended Court for part of the hearing. Her presence illustrated her courage and commitment at a time when she knew she may only have a few weeks to live.

[24] Ms Seales' brain tumour was diagnosed in March 2011. Since then Ms Seales has undergone surgery, courses of chemotherapy and radiation treatment. Despite this treatment, the brain tumour from which Ms Seales suffers is inoperable and will cause Ms Seales' death unless she dies from some other intervening event.

[25] On 1 April 2015 Ms Seales commenced a course of intravenous chemotherapy designed to slow the rate of growth of her brain tumour. Unfortunately, however, Ms Seales suffered severe adverse reactions to this treatment. On 24 April 2015, an oncologist recommended Ms Seales discontinue intravenous chemotherapy.

[26] By the time of the hearing Ms Seales was partially paralysed on the left side of her body, visually impaired and dependent on others for many day-to-day needs. Ms Seales continues to suffer from fatigue and has difficulty swallowing liquids. In addition, Ms Seales is suffering the side effects of steroids, which have been

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[15] Affidavit of Ms Seales' principal oncologist, 2 April 2015 at [12].

administered to her to reduce the effects of intracranial oedema[16] caused by her brain tumour.

[27] While Ms Seales' body is rapidly physically failing, her mind continues to function without impairment.

[28] Ms Seales has to date lived a very satisfying and fulfilling life. She is a successful lawyer who has enthusiastically pursued passions beyond her career. She has studied German, Spanish, Italian and Māori. She has also learnt to tango and acquired a range of culinary skills. Most importantly, Ms Seales has a close and loving relationship with her husband and family members.

[29] Ms Seales' approach to her final stages of life are best explained by quoting her own words from her first affidavit in this proceeding:[17]

> For the moment I will continue living my life every day as best I can. Despite my current disabilities and problems I do treasure every day and have no present desire to end my life. I do not lack courage. If my death is manageable I should be the one to manage it. But I cannot rule out that it will be unbearable even with palliative care. [Ms Seales' principal oncologist] acknowledges that, for many of my symptoms, palliative care will have minimal effect. This would include the loss of physical or mental capacity, being unable to swallow and the loss of the ability to communicate. While I understand that pain can usually be managed, there can be no guarantees that pain relief will address all pain. If pain relief is required in high doses, I am concerned that it could impact on my awareness of myself and my loved ones.
>
> As my death has become more inevitable, I constantly worry that it could be slow, unpleasant, painful and undignified. I worry that I will be forced to experience a death that is in no way consistent with the person that I am and the way that I have lived my life. I know that it might not turn out this way, but even the chance that it will is weighing on me very heavily.
>
> Because of this I have started thinking about what I could do to end my own life before I become physically unable. This is not a choice I want to make. I know that if I do take this action I would probably have to do that much earlier than I would if I could ask a doctor to assist me with my death. But my other choice is to face a possibly unbearable death.
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> My paralysis means that I am already limited in the methods I could use to end my life. However, there are still means available to me and I feel I have no choice but to consider them. I know that some of these methods might not work (eg poison or carbon monoxide) and could cause my family further

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[16] Swelling of the brain tumour within the cranium caused by the tumour's absorption of fluids.

[17] Affidavit of L Seales, 9 April 2015 at [47]-[54].

> suffering. I know that if I take my own life, I will need to do so alone and in secret to avoid the possibility of my loved ones being implicated. I hate the thought of going through that alone, with my loved ones having to find me, and not being able to say goodbye to them properly. If I wait too long to make this decision, I could become physically unable to take my own life other than by refusing food and water. I do not want to die that way but dying that way may still be more bearable than having to suffer through to the bitter end without choice.
>
> It seems incomprehensible to me that I can exercise a choice to end my life when I am able, and still have quality of life, but can't get any help to do so at a later point when my life no longer has any quality for me. I want to live as long as I can but I want to have a voice in my death and be able to say "enough".
>
> I am not depressed. I have accepted my terminal illness and manage it in hugely good spirits considering that it's robbing me of a full life. I can deal with that, and deal with the fact that I am going to die, but I can't deal with the thought that I may have to suffer in a way that is unbearable and mortifying for me.
>
> I have lived my life as a fiercely independent and active person. I have always been very intellectually engaged with the world and my work. For me a slow and undignified death that does not reflect the life that I have led would be a terrible way for my good life to have to end.
>
> I want to be able to die with a sense of who I am and with a dignity and independence that represents the way I have always lived my life. I desperately want to be respected in my wish not to have to suffer unnecessarily at the end. I really want to be able to say goodbye well.

[30] In a further affidavit, sworn in response to affidavits from some of the witnesses relied upon by the Attorney-General, Ms Seales reaffirmed:[18]

(1) She has not been coerced and no one has applied any pressure on her to seek confirmation that her decision to end her life with the assistance of her doctor will be respected.

(2) She has not been influenced by her doctor's views. On the contrary, it was Ms Seales who approached her doctor to ask her for assistance to end Ms Seales' life.

(3) She is not depressed or mentally compromised.

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[18] Affidavit of L Seales, 18 May 2015 (No 1) at [7]-[10].

(4) Her wishes reflect the way she has lived her life as an independent and intellectually engaged person.

Future treatment

[31] When Ms Seales commenced her proceeding, her principal oncologist explained that usually it is possible to provide palliative relief to patients in Ms Seales' circumstances to reduce the effect of any pain, nausea and seizures.[19]

[32] I have had the benefit of extensive evidence from clinicians who are experienced in treating patients in Ms Seales' circumstances. The experts who provided evidence at the request of Ms Seales included her principal oncologist and Professor Ashby, who practises as a palliative and pain medicine specialist in Australia, Dr Munglani, a consultant in pain medicine who practises in England, and Dr Smales, a palliative care physician in New Zealand. Professor Owens, who is a psychologist at the University of Auckland specialising in the psychology of end of life care, also gave evidence in support of Ms Seales' case.

[33] The clinical experts who provided evidence at the request of the Attorney-General included leading palliative care specialists in New Zealand and the United Kingdom. The Attorney-General obtained detailed statements of evidence from Baroness Finlay, a consultant physician in Wales and a member of the House of Lords, Professor O'Brien, a palliative care physician in Ireland, Professor George, a palliative care specialist in England, Professor R MacLeod, a palliative care specialist in New Zealand and Drs A Landers, S Donnelly and A S MacLeod, who are also palliative care specialists in New Zealand. Dr A S MacLeod is also a clinical psychiatrist. The Attorney-General also relied on the evidence of Professor Chochinov, a professor of psychiatry in Canada, who specialises in end of life issues. Ms Pickthorne, a palliative care nurse, and Ms Schumacher, the Chief Executive of Hospice New Zealand, also gave evidence at the request of the Attorney-General.

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[19] Affidavit of Ms Seales' principal oncologist, 2 April 2015 at [12].

[34] It is accepted that the development of palliative care medicine as a specialist branch of medicine and the establishment of hospices has greatly improved the clinical care of patients who are terminally ill.

[35] Palliative medicine was recognised as a specialty in the United Kingdom in 1987, in New Zealand in 2001, in Australia in 2005 and in the United States in 2006. The recognition of this specialist branch of medicine has greatly enhanced the care that is provided to the terminally ill. Similarly, the establishment of modern hospices since they were formed in Ireland in 1870, and then by Dame Celia Saunders in London in 1905, has led to significant improvements in the care of the terminally ill. Today, New Zealand has 29 hospices.

[36] All clinicians accept it is not possible to definitively state how Ms Seales will suffer during the final stages of her life. While I have been assisted by the observations of clinicians relied upon by the Attorney-General, I have found the evidence of Ms Seales' principal oncologist, Professor Ashby and Dr Smales most helpful because they have focused as best they can on Ms Seales' particular circumstances.

[37] I have been able to draw a number of conclusions from the evidence placed before me.

[38] First, palliative care cannot necessarily provide relief from suffering in all cases. The limits of palliative care were explained by Ms Seales' principal oncologist, experts who provided evidence in support of Ms Seales' case and some of the experts relied upon by the Attorney-General. However, some of the palliative care specialists who provided evidence at the request of the Attorney-General believe that Ms Seales' suffering may be successfully managed through palliative care.

[39] Ms Seales' principal oncologist explained:[20]

> … [I]t is usually possible to secure good relief of symptoms such as pain and nausea and to suppress seizure activity. However, loss of physical and mental capacity, behavioural changes and psychological impacts can only be ameliorated to a minimal extent.

[20] Affidavit of Ms Seales' principal oncologist, 22 May 2015 at [7].

[40] Professor Ashby explained that while "skilled palliative care can nearly always make a difference for the better", there are cases in which a patient's pain and distress do not respond to pain relief.[21] Dr Munglani provided similar evidence to Professor Ashby and said that "unfortunately, many pains are just not opiate sensitive".[22]

[41] Professor Ashby described in the following way the possible limitations of palliative relief for Ms Seales:

(1) First, the administration of steroids to reduce the effect of intracranial oedema has a number of very undesirable side effects. One side effect is a massive weight gain. Ms Seales has already begun to suffer this side effect. Steroids can also impair a patient's sleep, induce mood and behavioural changes and predispose patients to stomach ulcers and bleeding.

(2) Second, stopping or reducing steroids is likely to cause Ms Seales to suffer severe headaches until she dies. Professor Ashby has explained these headaches "tend to be difficult to control by morphine or other pain killers".[23]

(3) Third, in any event, a point will be reached when steroids will cease to be effective. This in turn is likely to increase intracranial pressure for Ms Seales, which in turn is likely to lead to a condition known as "coning". This occurs when the brain "herniates", or presses down the spinal canal, and puts pressure on the brain stem, causing the nervous system functions that control respiration and cardiac function to shut down. At this point Ms Seales is likely to be administered "palliative sedation".

(4) Fourth, palliative sedation can involve involve the administration of sedatives, benzodiazepines, anti-psychotics and/or occasionally

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21 Affidavit of M Ashby, 23 April 2015 at [13].
22 Affidavit of R Munglani, 22 April 2015 at [17].
23 Affidavit of M Ashby, 23 April 2015 at [33].

> barbiturates to maintain the comfort and dignity of the patient. At this point Ms Seales will not be able to interact with her husband and family.

[42] Dr Smales provided similar evidence. She said:[24]

> For most dying people in most situations good palliative care is absolutely what they need. Palliative care teams work exceptionally hard to address the emotional, physical, intellectual and spiritual issues associated with the dying process and are in most cases successful. But, there is a small percentage of people who face pain and suffering that we are unable to control while keeping the patient conscious.

[43] Baroness Finlay placed in context questions about the effectiveness of palliative care. She stated "there is no intervention in medicine that is 100% effective all the time".[25] She, however, explained that palliative care can in almost all cases relieve distress in those with terminal illnesses. Baroness Finlay took issue with some of the observations of Dr Munglani and Dr Smales concerning their views on the limits of palliative care.

[44] Professor O'Brien's evidence was similar to that of Baroness Finlay. Professor O'Brien acknowledged, however, that "there are sources of individual distress that are not responsive to analgesic drugs or interventions".[26] He explained that modern palliative care facilities manage those rare cases by "focusing on providing appropriate psychosocial, emotional and spiritual support".[27]

[45] Professor MacLeod, and Drs Allan and Donnelly also emphasised the importance and effectiveness of palliative care in treating terminally ill patients. They provided extensive evidence of their experiences of treating dying patients, almost all of whom experienced peaceful and dignified deaths. Ms Pickthorne provided similar evidence from her perspective as an experienced palliative care nurse.

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24 Affidavit of E A Smales, 23 April 2015 at [20].
25 Affidavit of Baroness I G Finlay, 6 May 2015 at [78].
26 Affidavit of P A O'Brien, 6 May 2015 at [19].
27 At [19].

[46] Second, experts who gave evidence in support of the case brought by Ms Seales and some of the experts who supported the position adopted by the Attorney-General agreed that pain is highly subjective.[28] This means that Ms Seales' perception of her pain is unimpeachable.

[47] Third, Ms Seales' circumstances are such that palliative care may not ameliorate her physical pain. I have reached this conclusion by relying primarily on the evidence of the experts who have given evidence on behalf of Ms Seales because they tailored their evidence to her particular circumstances.[29]

[48] Fourth, many of the experts, including those relied upon by the Attorney-General accept that palliative care may not be able to address Ms Seales' psychological and emotional suffering.[30]

Ms Seales' perspective

[49] Believing her prognosis is particularly unbearable, Ms Seales has identified in her amended statement of claim the following options she faces:[31]

(1) dying by way of "administered aid in dying",[32] or "facilitated aid in dying",[33] at the point that she reaches a state of suffering that is enduring and intolerable to her as a result of her grievous and terminal illness;

(2) intolerable suffering and loss of dignity; or

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28 Second Affidavit of M Ashby, 18 May 2015 at [20] and [29]; Second Affidavit of R G Owens, 18 May 2015 at [33]; Affidavit of Baroness I G Finlay, 6 May 2015 at [63]; Affidavit of R MacLeod, 21 May 2015 at [34].

29 Affidavit of R Munglani, 22 April 2015 at [22]; Affidavit of E A Smales, 23 April 2015 at [31]; Second Affidavit of M Ashby, 18 May 2015 at [30]; Affidavit of Ms Seales' principal oncologist, 2 April 2015 at [13]; Affidavit of Ms Seales' doctor, 30 April 2015 at [3]; Affidavit of R G Owens, 24 April 2015 at [8]-[9].

30 Affidavit of Ms Seales principal oncologist, 2 April 2015 at [15]; Affidavit of Ms Seales' principal oncologist, 22 May 2015 at [7]; Affidavit of R G Owens, 24 April 2015 at [9]-[10]; Affidavit of E A Smales, 23 April 2015 at [24]; Second Affidavit of M Ashby, 18 May 2015 at [4(e)]; Affidavit of R MacLeod, 21 May 2015 at [34]-[35]; Affidavit of P A O'Brien, 6 May 2015 at [20], [22] and [26].

31 Amended Statement of Claim of L Seales, above n 4, at [11].

32 Above at paragraph [5].

33 Above at paragraph [6].

(3) taking her own life while she is still physically able to do so in order to avoid that suffering, which could likely occur sooner than would be the case if administered aid in dying or facilitated aid in dying were available to her.

[50] Ms Seales "wishes to have the choice to die by way of facilitated aid in dying or administered aid in dying at the point that she reaches a state of suffering that is intolerable to her as a result of her grievous and terminal illness".[34]

[51] Evidence to support the proposition that people in Ms Seales' circumstances may shorten their lives can be found in the evidence of Dr Weaver, an historian from Canada who, together with Dr Munro, conducted extensive research into suicides in New Zealand between 1900 and 2000. That research suggests that between three and eight per cent of suicides in New Zealand during the last century were by persons who were rational, competent, and suffering a terminal illness. A number of the cases studied by Drs Weaver and Munro revealed suicides where the deceased persons took their lives when they retained the ability to do so, rather than waiting for their illness to cause further debilitation.[35]

[52] A number of clinical experts also provided evidence that persons in Ms Seales' position may attempt to take their lives before they reach a point where they would not be able to do so. Those experts were Dr Grube, Professor Owens, Dr Smales, Professor Ashby, Dr Reagan and Dr Kress.[36] Drs Grube and Reagan practised medicine in Oregon where it has been possible for doctors to assist patients in Ms Seales' circumstances to die since that state's Death with Dignity Act 1997 came into effect in 1999. Dr Kress practises medicine in Montana, where it has been possible for doctors to facilitate patients' deaths since the Supreme Court of Montana decided *Baxter v Montana*.[37]

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34 Amended Statement of Claim of L Seales, above n 4, at [12].

35 Affidavit of J C Weaver, 4 May 2015 at [15], [18], [20]-[22].

36 Affidavit of D R Grube, 24 April 2015 at [22]; Affidavit of R G Owens, 24 April 2015 at [15]; Affidavit of E A Smales, 23 April 2015 at [34], [36] and [40]; Affidavit of M Ashby, 23 April 2015 at [25]; Affidavit of P L Reagan, 1 May 2015 at [16]; Affidavit of E J Kress, 19 May 2015 at [15].

37 *Baxter v Montana*, above n 14.

[53] Ms Seales' evidence that she may have no choice but to take her own life prematurely also resonates with evidence from the United Kingdom referred to in *R (Nicklinson) v Ministry of Justice*, where Lord Neumberger said:[38]

> The evidence shows that, in the light of the current state of the law, some people with a progressive degenerative disease feel themselves forced to end their lives before they would wish to do so, rather than waiting until they are incapable of committing suicide when they need assistance (which would be their preferred option).

[54] Ms Seales' desire to control the final stages of her death is a common trait amongst those in society who consider themselves to be successful and driven. This trait was explained by Professor Owens, who said that people with Ms Seales' personality traits "frequently find the effects of an illness [of the kind suffered by Ms Seales] particularly intolerable because of the loss of autonomy and inability to manage their lives is directly contrary to the things they value".[39]

Ms Seales' doctor

[55] Ms Seales' doctor respects and understands Ms Seales' wishes. However, Ms Seales' doctor is not willing to assist Ms Seales in the way she wishes unless I grant the declarations I have set out in paragraph [8] of this judgment.

[56] Many health professionals regard the approach of Ms Seales' doctor as being the antithesis of the values which underpin the practice of medicine. Those doctors would not contemplate taking any steps to shorten a patient's life. This view of the role of health professionals in preserving life can be traced to the origins of the medical profession. Part of the original Hippocratic Oath required doctors to undertake not to succumb to any "entreaties … to administer poison to anyone [or] counsel any man to do so".[40]

[57] Dr Landers, a palliative care physician in New Zealand, explained that the Australian and New Zealand Society of Palliative Medicine (the ANZSPM) is completely opposed to doctor administered and facilitated aid in dying under any

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38 *R (Nicklinson) v Ministry of Justice*, above n 13, at [96].
39 Affidavit of R G Owens, 24 April 2015 at [9].
40 Ludwig Edelstein *The Hippocratic Oath: Text, Translation and Interpretation* (The Johns Hopkins Press, Baltimore, 1943) at 56.

circumstances. Dr Landers pointed out that the position taken by ANZSPM is entirely consistent with the New Zealand Medical Association's (the NZMA) opposition[41] to euthanasia and doctor-assisted suicide and position statements from the World Medical Association (the WMA).[42] Professor MacLeod's evidence supported the stance taken by Dr Landers.

[58] Dr Donnelly is very concerned about the ethical implications for doctors if I were to grant the criminal law declarations sought by Ms Seales. Dr Donnelly referred to the opposition to doctor-assisted suicide and euthanasia in the statements from the WMA, NZMA and ANZSPM. Dr Donnelly said those statements reflected "a core ethical principle of medicine: doctors do not kill their patients".[43]

[59] The approach of Ms Seales' doctor resonates, however, with the experiences of Drs Grube and Reagan, who provided evidence about their experiences in Oregon of being willing to assist terminally ill and competent patients to end their lives. In their experiences, patients in Ms Seales' circumstances feel empowered and reassured knowing that they can choose the time and surrounding circumstances in

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41 Affidavit of A L Landers, 4 May 2015 at [17]: The New Zealand Medical Association position statement, approved in 2005, states:
The NZMA is opposed to both the concept and practice of euthanasia and doctor assisted suicide. Euthanasia, that is the act of deliberately ending the life of a patient, even at the patient's request or at the request of close relatives, is unethical. Doctor-assisted suicide, like euthanasia, is unethical. The NZMA however encourages the concept of death with dignity and comfort, and strongly supports the right of patients to decline treatment, or to request pain relief, and supports the right of access to appropriate palliative care. In supporting patients' right to request pain relief, the NZMA accepts that the proper provisions of such relief, even when it may hasten the death of the patient, is not unethical. This NZMA position is not dependent on euthanasia and doctor-assisted suicide remaining unlawful. Even if they were to become legal, or decriminalised, the NZMA would continue to regard them as unethical.

42 Affidavit of A L Landers, 4 May 2015 at [21]-[22]: The World Medical Association's Declaration on Euthanasia was adopted by the 53rd WMA General Assembly, Washington DC, USA, in October 2002 and reaffirmed with minor revision by the 194th WMA Council Session, Bali, Indonesia, April 2013. It states:
Euthanasia, that is the act of deliberately ending the life of a patient, even at the patient's own request or at the request of close relatives, is unethical. This does not prevent the physician from respecting the desire of a patient to allow the natural process of death to follow its course in the terminal phase of sickness.
The WMA Statement on Physician-Assisted Suicide, adopted by the 44th World Medical Assembly, Marbella, Spain, September 1992 and editorially revised by the 170th WMA Council Session, Divonne-les-Bains, France, May 2005 likewise states:
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 is 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.

43 Affidavit of S M Donnelly, 12 May 2015 at [55].

which they die. Drs Grube and Reagan explained that their patients were often reassured by the knowledge that they had the option of having their doctors assist them to die, even if that option was not ultimately pursued. Both doctors also gave examples of terminally ill patients who died in a peaceful and controlled manner through taking a prescribed lethal medication while surrounded by their families and loved ones.[44]

[60] The experiences of Drs Grube and Reagan were summarised in the following way by Dr Reagan:[45]

> In my experience, [facilitated] aid in dying is beneficial to patients and to families. The [lethal drug] prescription itself is therapeutic because it helps foster better communication with loved ones and reduces significant sources of distress for those patients who desire aid in dying. For many patients, I believe that the ability to make autonomous decisions about their last days was of great importance to them. It was not something that came from me or is about me; and the final decision whether to use the drug or not was never one that I was able to predict. My patients had control over the final decision and they really valued that control.

[61] Dr Morris practises as an oncologist in New Mexico, where it has been held that doctors may lawfully provide a prescription for a lethal drug to a mentally competent, terminally ill patient.[46] Dr Morris' evidence was similar to that of Drs Grube and Reagan, as was the evidence of Dr Kress, who gave evidence of his experiences in Montana where the law is similar to that in New Mexico.[47]

Four principles

[62] Ms Seales' case engages four principles which require brief explanation. Those principles are:

(1) the sanctity of life;

(2) respect for human dignity;

(3) respect for individual autonomy; and

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44 Affidavit of D R Grube, 24 April 2015 at [21]; Affidavit of P L Reagan, 1 May 2015 at [25].
45 Affidavit of P L Reagan, 1 May 2015, at [26].
46 *Morris v Brandenberg*, above n 14.
47 *Baxter v Montana*, above n 14.

(4) protection of the vulnerable.

Sanctity of life

[63] The sanctity of human life principle underpins the criminal law relating to culpable homicide. It was said by Blackstone to be the first rule of English law.[48]

[64] The sanctity of life is not, however, an absolute principle. There are occasions where the principle of sanctity of life must yield to other principles, such as accepted standards of medical practice which recognise individual autonomy and human dignity. Thus, in *Airedale NHS Trust v Bland*, Lords Keith, Goff and Mustill all recognised limits to the principle of the sanctity of life. Lord Keith, for example, said:[49]

> … The principle [of the sanctity of life] is not an absolute one. It does not compel a medical practitioner on pain of criminal sanctions to treat a patient, who will die if he does not, contrary to the express wishes of the patient … It does not compel the temporary keeping alive of patients who are terminally ill where to do so would merely prolong their suffering. …

[65] The New Zealand approach to limits on the sanctity of life principle mirrors that of the United Kingdom. In *Auckland Area Health Board v Attorney-General*, the High Court of New Zealand held that doctors have no duty to maintain a patient on ventilatory support when doing so was not consistent with good medical practice.[50] A similar approach was taken in *Shortland v Northland Health Ltd*.[51] In that case an application was made to the High Court to direct the Northland Health Board to continue dialysis treatment for a patient who would die without a kidney transplant. On appeal, the Court of Appeal held that the Northland Health Board could not be compelled to continue to provide the patient with dialysis treatment because the decision of the Health Board was consistent with prevailing medical practices. In those cases the sanctity of life principle yielded to accepted standards of medical practice.

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48 *Blackstone's Commentaries on the Laws of England* (Clarendon Press, Oxford, 1765) vol 1 at 130.

49 *Airedale NHS Trust v Bland*, above n 12, at 859. See also Lords Goff at 865-866 and Mustill at 891.

50 *Auckland Area Health Board v Attorney-General*, above n 12.

51 *Shortland v Northland Health Ltd* [1998] 1 NZLR 433 (CA).

Respect for human dignity

[66] Ms Seales' application invokes respect for human dignity, which is the foundation of human rights theory and practice.[52] In *Stransham-Ford v Minister of Justice*, a case similar to that of Ms Seales which was decided by the High Court of South Africa on 4 May 2015, Fabricius J explained:[53]

> The right to life … incorporates the right to dignity. So the rights to dignity and to life are intertwined. The right to life is more than existence, it is a right to be treated as a human being with dignity: without dignity, human life is substantially diminished. Without life, there cannot be dignity.

[67] The importance of human dignity in the international human rights system is evidenced by its inclusion in major international human rights instruments. The first recital to the Universal Declaration of Human Rights provides that "recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world". The fifth recital notes that through the United Nations Charter, member states "reaffirmed their faith … in the dignity and worth of the human person". Article 1 states that "all human beings are born free and equal in dignity and rights".

[68] New Zealand human rights cases have emphasised the importance of human dignity.[54] For example, in *Attorney-General v Udompun*,[55] the Court of Appeal was required to consider s 23(5) of the NZBORA.[56]

[69] In *Udompun* Hammond J explained:[57]

> The starting point is that we are here talking about fundamental human dignity. This rests on the Kantian philosophy that requires us to treat every

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52 See Christopher McCrudden "Human Dignity and Judicial Interpretation of Human Rights" (2008) 19 EJIL 655 at 656.

53 *Stransham-Ford v Minister of Justice*, above n 14, at [12]; citing O'Reagan J in *S v Makwayane* [1995] ZACC 3, 1995 (3) SA 391 (CC).

54 *Taunoa v Attorney-General* [2007] NZSC 70, [2008] 1 NZLR 429 at [338] per McGrath J; *Helu v Immigration and Protection Tribunal* [2015] NZSC 28 at [67], [73]-[74] and [105] per Elias CJ; *Brooker v Police* [2007] NZSC 30, [2007] 3 NZLR 91 at [177]-[182] per Thomas J; and *Attorney-General v Udompun* [2005] 3 NZLR 204 (CA) at [196]-[203] per Hammond J.

55 *Attorney-General v Udompun*, above n 54.

56 **23 Rights of persons arrested or detained**
…
(5) Everyone deprived of liberty shall be treated with humanity and with respect for the inherent dignity of the person.

57 *Attorney-General v Udompun*, above n 54, at [200]-[201].

> human being as an end, not as a means. R M Dworkin, in *Taking Rights Seriously*, London, Duckworth, 1977 put the point this way:
>
> > "Anyone who professes to take rights seriously, and who praises our Government for respecting them, must have some sense of what that point is. He [or she] must accept, at the minimum . . . the vague but powerful idea of human dignity. This idea, associated with Kant, but defended by philosophers of different schools, supposes that there are ways of treating a [person] that are inconsistent with recognising [that person] as a full member of the human community, and holds that such treatment is profoundly unjust"
> > [P 198].
>
> Intrinsic dignity is not just a metaphysical concept. What such a concept does is to recognise human dignity as a universal value; as an inalienable value; and as a matter which is significantly tied up with human autonomy. And it must live and breathe in the real world. In that sense it is also a social construct. (See generally Fletcher G P, "Human Dignity as a Constitutional Value" (1984) 22 *UW Ont L Rev* 171; Raz J, *Value, Respect and Attachment*, Cambridge, Cambridge University Press, 2001, at pp 124 – 176; Schachter O, "Human Dignity as a Normative Concept" (1983) 77 *Am J In'l L* 848).

[70] The significance of the value of human dignity is also evident in leading cases in comparable jurisdictions. Thus, in *Carter v Canada (Attorney-General)*, the Supreme Court of Canada held that underlying the rights to liberty and security of the person is "a concern for the protection of individual autonomy and dignity".[58] The Supreme Court said an individual's respective sense of his or her bodily integrity and dignity in response to a grievous and irremediable medical condition was a matter "critical to their dignity and autonomy".[59] Similar observations have been made by the European Court of Human Rights.[60]

Respect for individual autonomy

[71] Ms Seales' application also relies on the principle of respect for individual autonomy. This concept is multi-faceted and subject to much debate. In this judgment, I refer to the concept of individual autonomy as encompassing:[61]

> … self-rule that is free from both controlling interference by others and limitations that prevent [the individual from making] meaningful choice[s] [about his or her body].

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58 *Carter v Canada (Attorney-General)*, above n 14, at [64].

59 At [66].

60 *Pretty v United Kingdom* , above n 14, at [65].

61 Tom L Beauchamp and James F Childress *Principles of Biomedical Ethics* (7th ed, Oxford University Press, New York, 2013) at 101.

[72] In New Zealand, respect for individual autonomy in some medical settings is reflected in s 11 of the NZBORA which states:

> **11 Right to refuse to undergo medical treatment**
>
> Everyone has the right to refuse to undergo any medical treatment.

[73] The applicability of the principle of respect for individual autonomy in this case is vigorously challenged by ethicists who are opposed to Ms Seales' application. For example, Dr Kleinsman explains in his evidence that assisted-suicide and euthanasia can never be viewed as expressions of individual autonomy.[62]

[74] From a legal perspective, respect for individual autonomy underpins the human rights principles of freedom, liberty and security of the person. Personal autonomy and self-determination have also featured in recent judgments in overseas jurisdictions concerning doctor-assisted dying.

[75] In *Carter*, the Supreme Court described the right to liberty and security of the person under s 7 of the Canadian Charter of Rights and Freedoms (the Canadian Charter) in the following way: [63]

> … Liberty protects "the right to make fundamental personal choices free from state interference" … Security of the person encompasses "a notion of personal autonomy … involving control over one's bodily integrity free from state interference" … and it is engaged by state interference with an individual's physical or psychological integrity, including any state action that causes physical or serious psychological suffering.

[76] In *Haas v Switzerland*, the European Court of Human Rights interpreted art 8 of the European Convention, which provides for the right to self-determination and a private life, as providing a basis for an inalienable right of personal autonomy in end of life decisions.[64]

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62 Affidavit of J Kleinsman, 12 May 2015 at [43]-[60].

63 *Carter v Canada (Attorney-General)*, above n 14, at [64].

64 *Haas v Switzerland* [2011] ECHR 2422 (Section I, ECHR) at [51].

Protecting the vulnerable

[77] Dr Kleinsman has explained vulnerability is a poorly understood concept and it may comprise a number of elements. He referred to research which suggests that vulnerability may include:

(1) communication vulnerability, represented by persons who are impaired in their ability to communicate because of distressing symptoms;

(2) institutional vulnerability, which refers to persons who exist under the authority of others;

(3) differential vulnerability, which includes persons who are subject to the informal authority or independent interests of others;

(4) medical vulnerability, which refers to those with distressing medical conditions; and

(5) social vulnerability, which includes persons who are considered to belong to an undervalued social group.

[78] Dr Kleinsman's approach to vulnerability clashes with the evidence of Professor Ganzini, a psychiatrist in Oregon, who has undertaken research into whether Oregon's laws relating to physician-assisted dying can put the vulnerable in society at risk. Professor Ganzini's research suggests that terminal illness is not in itself a factor that makes a patient vulnerable.

[79] A number of the clinicians who provided evidence at the request of the Attorney-General pointed out, however, that it can be very difficult to accurately assess if a patient is truly vulnerable. For example, Baroness Finlay said:[65]

> An individual's vulnerability to influence and to being made to feel despairing is highly personal and context-specific. Vulnerability can relate to learning difficulties, age, isolation, lack of mobility and any other factors.

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[65] Affidavit of Baroness I G Finlay, 6 May 2015 at [27].

Drs Donnelly and A MacLeod gave similar evidence, as did Professors George, R MacLeod and Chochinov.[66]

[80] In New Zealand, as in other enlightened democracies, all branches of government must be vigilant to protect the vulnerable in society. It is, however, important to ensure that medical judgements are not based upon assumptions as to vulnerability. To do otherwise would devalue respect for the principle of individual autonomy.

[81] In the present case, Ms Seales has consistently maintained that she is not vulnerable in any of the senses referred to by Dr Kleinsman. She says that, notwithstanding her medical condition, her wishes have been carefully considered and reasoned. Ms Seales' self-assessment that she is not vulnerable is endorsed by her doctor, who has consistently said Ms Seales is pursuing her requests in a positive, rational manner without showing any signs of depression or lack of full appreciation of her circumstances. Ms Seales' statement of her belief that she is not vulnerable must be respected. Ms Seales' application for the declarations she seeks is a rational and intellectually rigorous response to her circumstances.

PART II

CRIMINAL LAW PROVISIONS

Background

[82] In Part II of this judgment I analyse the offence provisions of the Crimes Act. For convenience I will set out the offence provisions again:

> **160 Culpable homicide**
>
> ...
>
> (2) Homicide is culpable when it consists in the killing of any person–
>
> (a) By an unlawful act…

[66] Affidavit of S M Donnelly, 12 May 2015 at [48] and [75]-[88]; Affidavit of A MacLeod, 11 May 2015 at [23]-[27]; Affidavit of R George, 14 May 2015 at [98]-[103]; Affidavit of R MacLeod, 21 May 2015 at [20]-[25] and [49]-[56]; Affidavit of H Chochinov, 19 May 2015 at [26] and [32]-[43].

…

(3) … culpable homicide is either murder or manslaughter.

179 Aiding and abetting suicide

Every one is liable to imprisonment for a term not exceeding 14 years who–

…

(b) Aids or abets any person in the commission of suicide.

[83] This part of my judgment includes an analysis of ss 63 and 164 of the Crimes Act, which assist in understanding the culpable homicide provisions of the Crimes Act.

[84] Section 63 of the Crimes Act provides:

63 Consent to death

No one has a right to consent to the infliction of death upon himself; and, if any person is killed, the fact that he gave any such consent shall not affect the criminal responsibility of any person who is a party to the killing.

[85] Section 164 of the Crimes Act provides:

164 Acceleration of death

Every one who by any act or omission causes the death of another person kills that person, although the effect of the bodily injury caused to that person was merely to hasten his death while labouring under some disorder or disease arising from some other cause.

[86] The parties agree that the duty to preserve life provisions of the Crimes Act are not relevant to Ms Seales' applications.[67]

[87] The legislative origins of the provisions of the Crimes Act, which are the focus of this part of my judgment, can be traced to the Criminal Code Act 1893. That statute was the product of a series of steps taken in England dating back to 1833 to codify that jurisdiction's criminal law. The steps taken in England culminated in the appointment of the Criminal Code Commission in 1878 to consider a draft criminal code. The draft code which was developed is usually referred to as

[67] Refer Crimes Act 1961, ss 151 and 155.

"Stephen's Code".[68] Stephen's Code was never adopted in England. As a consequence, the criminal law of England and Wales is an amalgam of common law and specific legislative provisions. Stephen's Code was, however, adopted in New Zealand in 1893 and in other jurisdictions including Canada.

[88] In undertaking the legislative analysis required in this part of my judgment, I have focused upon the text and purpose of the relevant provisions of the Crimes Act.[69] In doing so, I have found it helpful to refer to Sir James Stephen's descriptions of the common law at the time Stephen's Code was drafted. Appreciating the common law from which the relevant sections are derived assists in understanding the meaning of those sections. I have also strived to interpret the Crimes Act in the context of contemporary circumstances,[70] recognising that the meaning of legislation is not fixed in perpetuity and that the requirements of s 6 of the NZBORA mean legislation may have to be given an interpretation that was not envisaged at the time of its enactment.[71]

Consent to death

[89] Mr Curran, who appeared with Dr Butler as counsel for Ms Seales, submitted s 63 of the Crimes Act should be construed so as not to preclude consent as a defence to either murder or manslaughter where the deceased has lawfully asserted his or her NZBORA rights. Mr Curran also suggested s 63 is directed at prohibiting people from consenting to death by violent acts that are contrary to public policy.

[90] At common law no person could consent to being killed. Sir James Stephen explained this aspect of the common law in the following way:[72]

> Where death is caused the consent of the party killed to his own death is regarded as wholly immaterial to the guilt of the person who causes it.

[91] Sir James Stephen illustrated the purpose of s 63 of the Crimes Act by saying:[73]

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68 The Chairman of the Criminal Code Commission was Sir James Fitzjames Stephen.
69 Interpretation Act 1999, s 5(1).
70 Section 6.
71 *R v Hansen* [2007] NZSC 7, [2007] 3 NZLR 1 at [14].
72 Sir James Stephen *A History of the Criminal Law of England* (McMillan and Co, London, 1883) vol 3 at 16.

> A and B agree to fight a duel together with deadly weapons. If either is killed or wounded his consent is immaterial.

[92] The broad scope of the common law prohibition against a person consenting to his or her own death appears to have been adopted unquestioningly in New Zealand in *Rex v McLeod*.[74] In that case, the Court of Appeal relied on the extract from Sir James Stephen which I have cited in paragraph [90].

[93] Modern authority suggests, however, that s 63 of the Crimes Act is only engaged in cases where death is intentionally inflicted. This was acknowledged by the Court of Appeal in *R v Lee* where it was said:[75]

> … no person can consent to the (intentional) infliction of death upon him or herself including (probably) murder …

and that s 63 of the Crimes Act:[76]

> … does not apply to homicide by misadventure in cases where the common law regards consent as rendering lawful an act which otherwise would not be lawful. …

Where grievous bodily harm is intended, however, there may be sound policy reasons for excluding consent as a defence.[77]

[94] The Court of Appeal's approach to s 63 of the Crimes Act in *Lee* is consistent with the modern common law. In England and Wales the validity of consent to being injured or even killed is determined by the level of harm done and the circumstances in which it is inflicted. Thus, today in England and Wales, consent can provide a lawful excuse for the infliction of harm caused by an assault. A victim cannot, however, give valid consent to more serious levels of harm such as wounding or the infliction of death unless the injury or death occurs in a context in which the courts or Parliament have said the victim's consent provides a lawful excuse for the harm done. In England and Wales, as in New Zealand, it is no

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73 Sir James Fitzjames Stephen *A Digest of the Criminal Law* (4th ed, MacMillan and Company, London, 1887) at art 207.
74 *Rex v McLeod* (1915) 34 NZLR 430 (CA) at 433.
75 *R v Lee* [2006] 3 NZLR 42 (CA) at [312].
76 *R v Lee*, above n 75, at [165].
77 *R v Lee*, above n 75, at [300].

defence to a charge of murder for the defendant to say the victim consented to being killed.

[95] On the other hand, the victim's consent to undergoing a properly performed but risky surgical procedure may, for example, provide the surgeon with a lawful excuse and complete defence to any criminal charge even though serious injury or death may occur. This is the effect of the common law,[78] and s 61 of the Crimes Act which provides:

> **61 Surgical operations**
>
> Every one is protected from criminal responsibility for performing with reasonable care and skill any surgical operation upon any person for his benefit, if the performance of the operation was reasonable, having regard to the patient's state at the time and to all the circumstances of the case.

[96] Applying a textual and purposive approach to the meaning of s 63 of the Crimes Act has led me to the conclusion that where A kills B by an unlawful act with the intention of bringing about B's death, the consent of B to the infliction of death cannot affect A's criminal responsibility.

[97] The approach I have taken to the meaning of s 63 mirrors the law of the United Kingdom, which was explained by Lord Mustill in the following way:[79]

> It has been established for centuries that consent to the deliberate infliction of death is no defence to a charge of murder. Cases where the victim has urged the defendant to kill him and the defendant has complied are likely to be rare, but the proposition is established beyond doubt …

[98] Lord Mustill went on to observe that the reason why a person cannot consent to that type of infliction of death, sometimes referred to as "mercy killing", is because "as in the other cases of consent to being killed, the interest of the state in preserving life overrides the otherwise all-powerful interest of patient autonomy".[80]

[99] I therefore conclude that Ms Seales' consent would not provide a lawful excuse to Ms Seales' doctor if she "administered aid in dying" to Ms Seales.

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78 David Ormerod *Smith and Hogan's Criminal Law* (13th ed, Oxford University Press, New York, 2011) at 635.

79 *Airedale NHS Trust v Bland*, above n 12, at 892.

80 At 893.

Acceleration of death

[100] Section 164 of the Crimes Act reflects the common law position that a person may be criminally responsible for a death if he or she causes it to occur sooner than it would otherwise have happened.[81] The acts or omissions in question must, however, constitute more than a minimal contribution to death.[82]

[101] Importantly in the context of palliative care, acts or omissions that have the indirect but foreseeable effect of accelerating death are not necessarily criminally culpable. Ethicists refer to this as the "double effect" principle, the origins of which are often traced to the writings of St Thomas Aquinas.[83]

[102] According to the double effect principle there is a morally relevant distinction between the intentional effects of a person's acts or omissions and the unintended, though foreseeable, effects of those actions.

[103] The double effect principle is underpinned by four conditions, each of which have been questioned by ethicists.[84] An example of the double effect principle is helpfully explained in the following way:[85]

> … consider a patient experiencing terrible pain and suffering who asks a physician for help in ending his life. If the physician injects the patient with a chemical to end the patient's pain and suffering, he or she intentionally causes the patient's death as a means to end pain and suffering. The physician's action is wrong because it involves the intention to cause the patient's death. In contrast, suppose the physician could provide medication to relieve the patient's pain and suffering at a substantial risk that the patient would die as a result of the medication. If the physician refuses to

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81 *R v Dyson* [1908] 2 KB 454 at 457.

82 Henry Palmer "Dr Adams' Trial for Murder" [1957] Crim LR 365; *R v Cox* (1992) 12 BMLR 38.

83 Tom L Beauchamp and James F Childress *Principles of Biomedical Ethics*, above n 61, at 164, footnote 33.

84 See Tom L Beauchamp and James F Childress *Principles of Biomedical Ethics*, above n 61, at 165: The four underpinning conditions upon which the double effect principle depends are:
(1) The nature of the act. The act must be at least morally neutral, independent of its consequences.
(2) The agent's intention. The person carrying out the act must only have intended the good not the bad effect.
(3) The distinction between the means and effect. The bad effect must not be a means to the good effect.
(4) Proportionality between the good effect and the bad effect. The good effect must outweigh the bad effect.

85 Tom L Beauchamp and James F Childress *Principles of Biomedical Ethics*, above n 61, at 164-165.

> administer the medication, the patient will endure continuing pain and suffering; if the physician provides the medication, it may hasten the patient's death. If the physician intended, through the provision of medication, to relieve grave pain and suffering and did not intend to cause death, then the act of indirectly hastening death is not wrong, according to the [double effect principle].

[104] The double effect principle was applied by Lord Devlin in *R v Adams* when he addressed the culpability of a doctor charged with murder in circumstances where the doctor administered increasing doses of morphine to a terminally ill patient, who died as a consequence.[86] Lord Devlin addressed the jury in the following way:[87]

> … If the first purpose of medicine – the restoration of health – could no longer be achieved, there was still much for the doctor to do, and he was entitled to do all that was proper and necessary to relieve pain and suffering even if the measures he took might incidentally shorten life by hours or perhaps even longer.

[105] Similar observations were made by Lord Goff in *Airedale NHS Trust v Bland* when he said:[88]

> ... the established rule that a doctor may, when caring for a patient who is, for example, dying of cancer, lawfully administer painkilling drugs despite the fact that he knows that an incidental effect of that application will be to abbreviate the patient's life ...

[106] Thus, if Ms Seales' doctor were to administer a lethal dose of pain relief such as morphine to Ms Seales, the doctor's actions may not be an unlawful act within the meaning of s 160(2)(a) of the Crimes Act if the doctor's intention was to provide Ms Seales with palliative relief, and provided that what was done was reasonable and proper for that purpose, even though Ms Seales' life would be shortened as an indirect but foreseeable consequence.

Murder/manslaughter

[107] Section 160(2)(a) and (3) of the Crimes Act provide that the killing of another person by an unlawful act is culpable homicide and that culpable homicide is either

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86 Henry Palmer "Dr Adams' Trial for Murder", above n 82.

87 At 375.

88 *Airedale NHS Trust v Bland*, above n 12, at 867. See also *R (Burke) v General Medical Council* [2006] QB 273 and Dupre "Human Dignity and the Withdrawal of Medical Treatment" (2006) 6 EHRLR 678.

murder or manslaughter. "'Homicide' is the killing of a human being by another, directly or indirectly, by any means whatsoever".[89]

[108] The purpose of the law of culpable homicide is to protect human life.[90]

[109] At common law, the concept of an "unlawful act" in the context of homicide was explained in very broad terms. Sir James Stephen explained that "homicide caused accidentally by an unlawful act is unlawful". He believed the concept of an "unlawful act" included "all crimes, all torts, and all acts contrary to public policy or morality, or injurious to the public; and particularly all acts commonly known to be dangerous to life".[91]

[110] Sir James Stephen's broad analysis of what constituted an "unlawful act" no longer reflects the law of England and Wales. In *R v Lamb* it was held that to be an unlawful act for the purposes of manslaughter the act must be "unlawful in the criminal sense of that word".[92] The law in England and Wales as to what constitutes an unlawful act for the purposes of determining if a homicide is culpable was further refined in *R v Dias* and *R v Kennedy (No 2)*, where it was held that an "unlawful act" must be an offence.[93] A similar approach had been taken in New Zealand in *R v Myatt*, where the Court of Appeal said that an "unlawful act" for the purposes of s 160(2)(a) of the Crimes Act must be a breach of "some Act, regulation or bylaw".[94]

[111] In New Zealand the term "unlawful act" is now defined in the Crimes Act to mean "a breach of any Act, regulation, rule or bylaw".[95] The definition of "unlawful act" was introduced with effect from 2012 and followed the recommendations of the Law Commission in its *Review of Part 8 of the Crimes Act 1961: Crimes against the Person*, which suggested that its proposed statutory definition codified the law as stated in *Myatt*.[96] It is clear, however, the definition of an "unlawful act" in the

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89 Crimes Act 1961, s 158.

90 *R v Stead* (1991) 7 CRNZ 291 (CA) at 295; *R v Martin* CA199/04, 14 February 2005 at [168].

91 Sir James Stephen *A History of the Criminal Law of England*, above n 72, at 16.

92 *R v Lamb* [1967] 2 QB 981 (CA) at 988. See also *R v Dias* [2002] 2 Cr App R 5 (CA); *R v Kennedy (No 2)* [2008] 1 AC 269.

93 *R v Dias*, above n 92; *R v Kennedy (No 2)*, above n 92.

94 *R v Myatt* [1991] 1 NZLR 674 (CA).

95 Crimes Act 1961, s 2 (1).

96 Law Commission *Review of Part 8 of the Crimes Act 1961: Crimes against the Person* (NZLC R111, 2009) at [25] and [4.14].

Crimes Act expands upon the approach taken in *R v Myatt* by recognising that a breach of a rule may constitute an unlawful act. This approach is also broader than the position in England and Wales as articulated in *R v Kennedy (No 2)*.

[112] The breadth of the definition of an "unlawful act" in the Crimes Act means that it is not necessary for the prosecution to establish the commission of a specific offence in order to establish an unlawful act for the purposes of s 160(2)(a) of the Crimes Act. Evidence of a breach of a "rule" will suffice. I will not attempt to suggest what "rule" would be breached, if any, if Ms Seales' doctor was to administer "aid in dying" to Ms Seales. It is sufficient to note that if Ms Seales' doctor were to administer a fatal drug to Ms Seales with the intention of terminating her life, two offences may be committed.[97]

[113] First, the doctor would probably commit an assault, which is an offence under s 196 of the Crimes Act.[98] By administering a lethal drug, Ms Seales' doctor would intentionally apply force to Ms Seales, either directly or indirectly, by the lethal drug being inserted into Ms Seales, or through the pharmacological effects of the lethal drug upon Ms Seales' body.

[114] Second, the doctor would, in all likelihood, also breach s 200 of the Crimes Act, which makes it an offence to administer a poison or other noxious substance to another person intending to cause them grievous bodily harm.[99]

[115] The approach which I have taken to the meaning of s 160(2)(a) of the Crimes Act in this case is consistent with doctors not being criminally culpable when they withdraw life preserving measures which artificially sustain life in circumstances which are medically futile. Doctors who withdraw ventilatory support for a patient, knowing that doing so will invariably result in the patient's death, may have a lawful excuse for doing so where to continue ventilatory support would be medically futile.

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97 PDG Skegg and Ron Paterson (eds) *Medical Law in New Zealand* (Thomson Brookers, Wellington, 2006) at 511-512.

98 Crimes Act 1961, s 2: **Assault** means the act of intentionally applying or attempting to apply force to the person of another, directly or indirectly, or threatening by any act or gesture to apply such force to the person of another, if the person making the threat has, or causes the other to believe on reasonable grounds that he has, present ability to effect his purpose.

99 See *R v Burkholder* (1977) 2 AR 119, (1977) 34 CCC (2d) 214 (ABCA); *R v Clark* (2008) ABCA 271 (ABCA).

In those cases, the doctors concerned are unlikely to commit an unlawful act for the purposes of s 160(2)(a) of the Crimes Act.[100]

Assisting suicide

[116] At common law anyone who assisted another to commit suicide was guilty of murder.[101] This reflected the religious and social condemnation of those who committed suicide or those who assisted others to commit suicide.[102] The stigma of suicide in England was such that a normal church burial for those who committed suicide was not able to be achieved until 1882.[103]

[117] Although there is no legislative definition of suicide in New Zealand, Sir James Stephen said the "true definition" of suicide was "where a man kills himself intentionally".[104]

[118] In New Zealand suicide ceased to be a crime when the Criminal Code Act 1893 was enacted. Attempting suicide ceased to be a crime in 1961 when a number of changes were made in the Crimes Act concerning suicide. Section 179 of the Crimes Act was the only provision relating to suicide that was not changed in 1961.

[119] In addition to decriminalising attempting suicide, the Crimes Act 1961 enacted s 180, which introduced into New Zealand law the criminal offence of killing another person pursuant to a suicide pact.[105] Section 180 of the Crimes Act was modelled on s 4 of the Homicide Act 1957 (UK).

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100 *Auckland Area Health Board v Attorney-General*, above n 12; *Airedale NHS Trust v Bland*, above n 12.

101 *R v Dyson* (1823) Russ & Ry 523; *R v Alison* (1838) 8 C & P 418; *R v Jessop* (1887) 16 Cox CC 204.

102 *Blackstone's Commentaries on the Laws of England*, above n 48, vol 4 at 189: "… the law of England wisely and religiously considers that no man hath a power to destroy life, but by commission from God, the author of it: and, as the suicide is guilty of a double offence; one spiritual, and invading the prerogative of the Almighty, and rushing into his immediate presence uncalled for; the other temporal, against the King, who hath an interest in the preservation of all his subjects; the law has therefore ranked this among the highest crimes, making it a particular species of felony, a felony committed on oneself".

103 See Sir James Stephens *A History of the Criminal Law of England*, above n 72, at 104-105.

104 At 104.

105 **180 Suicide pact**

(1) Every one who in pursuance of a suicide pact kills any other person is guilty of manslaughter and not of murder, and is liable accordingly.

(2) Where 2 or more persons enter into a suicide pact, and in pursuance of it one or more of them kills himself, any survivor is guilty of being a party to a death under a suicide pact

[120] In 1961 Parliament also made changes to what is now s 41 of the Crimes Act. That section provides:

> **41 Prevention of suicide or certain offences**
>
> Every one is justified in using such force as may be reasonably necessary in order to prevent the commission of suicide, or the commission of an offence which would be likely to cause immediate and serious injury to the person or property of any one, or in order to prevent any act being done which he believes, on reasonable grounds, would, if committed, amount to suicide or to any such offence.

[121] The provision which s 41 was broadly based upon was s 72 of the Crimes Act 1908.[106] Section 72 of the Crimes Act 1908 re-enacted s 55 of the Criminal Code Act 1893.

[122] When Parliament enacted s 41 of the Crimes Act, it provided a justification for using reasonable force to prevent the commission of any suicide. A similar provision has since been enacted in the State of Victoria.[107]

[123] The Canadian Criminal Code, which is modelled on Stephen's Code, does not contain a provision equivalent to s 41 of the Crimes Act.[108] Nor does the United Kingdom appear to have a statutory provision that is similar to s 41, although in that jurisdiction there may be a common law defence to use reasonable force to prevent a suicide.

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contrary to this subsection and is liable to imprisonment for a term not exceeding 5 years; but he shall not be convicted of an offence against section 179 of this Act.

(3) For the purposes of this section the term **suicide pact** means a common agreement between 2 or more persons having for its object the death of all of them, whether or not each is to take his own life; but nothing done by a person who enters into a suicide pact shall be treated as done by him in pursuance of the pact unless it is done while he has the settled intention of dying in pursuance of the pact.

(4) It shall be for the person charged to prove that by virtue of subsection (1) of this section he is not liable to be convicted of murder, or that by virtue of subsection (2) of this section he is not liable to be convicted of an offence against section 179 of this Act.

(5) The fact that by virtue of this section any person who in pursuance of a suicide pact has killed another person has not been or is not liable to be convicted of murder shall not affect the question whether the homicide amounted to murder in the case of a third person who is a party to the homicide and is not a party to the suicide pact.

106 **72 Prevention of certain offences –**
Every one is justified in using such force as may be reasonably necessary in order to prevent the commission of an offence for which an offender might be arrested without warrant, and the commission of which would be likely to cause immediate and serious injury to the person or property of anyone, or in order to prevent any act being done which he believes, on reasonable grounds, would, if committed, amount to any such offence.

107 Crimes Act 1958 (Vic), s 463B, amended by Crimes Act 1967, No. 7546/1967.

108 Criminal Code RSC 1985 c 46.

[124] In *Carter*, the Supreme Court of Canada reasoned the purpose of the prohibition upon assisting a person to commit suicide is to protect the vulnerable in society. The Supreme Court said that:[109]

> … [T]he direct target of [the law against assisting suicide] is the narrow goal of preventing vulnerable persons from being induced to commit suicide at a time of weakness.

[125] Similar observations were made by Baroness Hale in her dissenting judgment in *R (Nicklinson) v Ministry of Justice*, where she observed:[110]

> The only legislative aim which has been advanced for [the prohibition on assisting suicide] is the protection of vulnerable people, those who feel that their lives are worthless or that they are a burden to others and therefore that they ought to end their own lives even though they do not wish to do so.

[126] It is also to be noted that in *Pretty v United Kingdom*,[111] the European Court of Human Rights said that the provision in the Suicide Act 1961 (UK) which prohibited assisting suicide "was designed to safeguard life by protecting the weak and vulnerable and especially those who are not in a condition to make informed decisions against acts intended to end life or to assist in ending life".

[127] It was submitted on behalf of Ms Seales that the only purpose to s 179 of the Crimes Act is to protect the vulnerable in society, and that the changes made to the Crimes Act in 1961 reflected Parliament's intention that when giving effect to s 179(b) of the Crimes Act, the principle of individual autonomy should prevail over the sanctity of life. This submission owed its genesis to the passages in *Carter* and *R (Nicklinson) v Ministry of Justice* which I have cited in paragraphs [124] and [125].

[128] Section 41 of the Crimes Act does not distinguish between the vulnerable and those who might commit a "rational suicide". If s 41 is to have any effect, it must apply to all suicides.

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109 *Carter v Canada (Attorney-General)*, above n 14, at [78].
110 *R (Nicklinson) v Ministry of Justice*, above n 13, at [311]. See also Lord Mance at [171].
111 *Pretty v United Kingdom*, above n 14, at [74].

[129] Parliamentary records relating to the second reading of the Crimes Bill 1961 confirm that attempting suicide was decriminalised for humanitarian reasons. The Hon Ralph Hanan explained:[112]

> …[A]ttempted suicide will no longer be an offence. For many years charges of attempted suicide have been brought almost solely to enable those unfortunate people who try to commit suicide to be taken and looked after. However, there are better ways of doing that than by convicting them of a criminal offence … An amendment to the Health Act last year … provided for different procedure … for us still to have it in the criminal law is what one might call humanitarian misuse of the criminal law, so by this bill the crime of attempting to commit suicide goes out.

[130] The decriminalisation of attempted suicide in New Zealand occurred at the same time similar changes were made in the United Kingdom by the Suicide Act 1961 (UK).

[131] Lord Bingham explained the effect of the changes made in the United Kingdom in the following way:[113]

> Suicide itself (and with it attempted suicide) was decriminalised because recognition of the common law offence was not thought to act as a deterrent, because it cast an unwarranted stigma on innocent members of the suicide's family and because it led to the distasteful result that patients recovering in hospital from a failed suicide attempt were prosecuted, in effect, for their lack of success. But while the 1961 Act abrogated the rule of law whereby it was a crime for a person to commit (or attempt to commit) suicide, it conferred no right on anyone to do so. Had that been its object there would have been no justification for penalising by a potentially very long term of imprisonment one who aided, abetted, counselled or procured the exercise or attempted exercise by another of that right. The policy of the law remained firmly adverse to suicide…

[132] The decriminalisation of attempted suicide in New Zealand, combined with the retention of s 179 and the adoption of ss 41 and 180 demonstrate Parliament gave effect to two objectives. First, the absolute protection of the lives of all who are vulnerable. Second, recognising that suicide is not an offence, s 179 aims to protect, so far as is reasonably possible, the lives of those who are not vulnerable. I do not think the changes made to the suicide laws in 1961 involved Parliament placing respect for personal autonomy over the sanctity of human life. As Lord Bingham

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112 (3 October 1961) 328 NZPD 2682.

113 *R (Pretty) v Director of Public Prosecutions (Secretary of State for the Home Department intervening)*, above n 14, at [35]. See also Lord Hope at [106]; and *R (Nicklinson) v Ministry of Justice*, above n 13, at [212] per Lord Sumption JSC.

noted, the policy of the law remained firmly adverse to suicide. The purpose of s 179 of the Crimes Act in the New Zealand context is broader than the equivalent law in Canada and is not confined to protecting the vulnerable in society.

[133] The approach I have taken when determining the purpose of s 179 of the Crimes Act reflects approaches taken by New Zealand courts when considering sentences following convictions under s 179. In *R v Ruscoe*, Cooke P, when the Court of Appeal quashed a prison sentence for a conviction under s 179, noted:[114]

> … There are obviously many occasions, perhaps most occasions, of aiding suicide where a custodial sentence will be required by the paramount dictates of the principle of sanctity of human life.

[134] Ms Seales' application also challenges what constitutes suicide for the purposes of the Crimes Act. Ordinary dictionary definitions of suicide say that suicide is "the intentional killing of oneself".[115]

[135] Mr Curran suggested that the term "suicide" in s 179 of the Crimes Act can be interpreted to exclude from its ambit "rational decisions to die".[116] Mr Curran submitted there is a distinction between suicide which he says is "irrational and a product of impaired thinking" and a "rational decision to die" by a mentally competent adult who is not depressed but is enduring a terminal illness.[117]

[136] The appropriateness of the ordinary meaning of suicide in all cases where the deceased takes his or her own life has been called into question by a number of philosophers, such as Emile Durkheim[118] and Manuel Velasqueiz.[119] It is argued, for example, that a person who is coerced into taking his or her own life should not be considered a case of suicide.

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114 *R v Ruscoe* (1992) 8 CRNZ 68 (CA) at 70. See also *R v Mott* [2012] NZHC 2366 at [12].

115 HW Fowler and FG Fowler *The Concise Oxford Dictionary* (9th ed, Clarendon Press, Oxford, 1995) at 1393.

116 Plaintiff's submissions, 18 May 2015 at [8.4].

117 At [8.9].

118 Emile Durkheim *Suicide: A Study in Sociology* translated by John A Spaulding and George Simpson (New York Free Press, New York, 1966).

119 Manuel Velasquez "Defining Suicide", in Tom L Beauchamp and Robert M Veatch *Ethical Issues in Death and Dying* (2nd ed, Prentice Hall Inc, Upper Saddle River, New Jersey, 1996) at 106-111..

[137] Professor Beauchamp frames the issue by suggesting that a person who is handed a cyanide pill and told that unless he or she kills him or herself, his or her family will be put to death, does not commit suicide because he or she has not acted voluntarily.[120] Similarly, the soldier who sacrifices his or her own life on a battlefield by falling onto a grenade to save his or her comrades is generally regarded as a hero rather than a person who has committed suicide. In that case, the soldier's death is not branded as an act of suicide because he or she has acted altruistically, in the greater good to save others.

[138] Mr Heron QC, the Solicitor-General, appeared with Professor Rishworth QC as counsel for the Attorney-General. He submitted that a patient who declines or wishes to no longer receive life sustaining medical procedures does not commit suicide when, for example, he or she dies following removal from a ventilator. Support for this approach can be found in the judgment of Lord Goff in *Airedale NHS Trust v Bland*, who observed that:[121]

> … in cases of this kind, there is no question of the patient having committed suicide, nor therefore of the doctor having aided or abetted him in doing so.

[139] Some philosophers and ethicists also question the appropriateness of ordinary conceptions of suicide where a competent terminally ill patient obtains assistance to end his or her life from a medical practitioner.[122] Supporters of Ms Seales' case say that a rational, competent and terminally ill patient who ends his or her own life by taking a fatal drug is not in a substantially different position from a person who declines to receive life sustaining medical services. However, such views are not universally accepted. There are many who suggest there is no concept as "rational suicide".[123]

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120 Tom L Beauchamp "The Problem of Defining Suicide", above n 199, at 113-118.

121 *Airedale NHS Trust v Bland*, above n 12, at 864.

122 See for example, Tom L Beauchamp "The Right to Die as the Triumph of Autonomy" (2006) Journal of Medicine and Philosophy 31 (6) at 643-654; Tom L Beauchamp "When Hastened Death is Neither Killing Nor Letting Die" in *Physician-assisted Dying* T E Quill and M P Battin (eds) (John Hopkins University Press, Baltimore, 2004) at 118-129.

123 Michael McGonnigal "This is Who Will Die When Doctors Are Allowed to Kill Their Patients" (1997) 31 J Marshall L Rev 95; Yale Kamisar "Against Assisted Suicide – Even A Very limited Form" (1995) U Det Mercy L Rev 735; Affidavit of Baroness I G Finlay, 6 May 2015 at [42]; Affidavit of H Chochinov, 19 May 2015 at [60]; Affidavit of R George, 14 May 2015 at [80]-[85].

[140] The approach to the meaning of "suicide" submitted on behalf of Ms Seales faces challenges in giving effect to s 41 of the Crimes Act. It is difficult to see how a person who intervenes to prevent a suicide can assess whether or not he or she is intervening in a case of "rational" suicide.

[141] Mr Curran drew attention to a passage in *Baxter v Montana* concerning the meaning of "suicide". In that judgment, Nelson J said:[124]

> "Suicide" is a pejorative term in our society … The term denigrates the complex individual circumstances that drive persons generally – and, in particular, those who are incurably ill and face prolonged illness and agonizing death – to take their own lives. The term is used to generate antipathy, and it does. The Patients and the class of people they represent do not seek to commit "suicide". Rather they acknowledge that death within a relatively short time is inescapable because of their illness or disease. And with that fact in mind, they seek the ability to self-administer, at a time and place of their choosing, a physician-prescribed medication that will assist them in preserving their own human dignity during the inevitable process of dying. Having come to grips with the inexorability of their death, they simply ask the government not to force them to suffer and die in an agonizing, degrading, humiliating, and undignified manner. They seek nothing more nor less; …

[142] While *Baxter* provides a point of reference, the issue the Supreme Court of Montana had to consider is not directly applicable to Ms Seales' case. In Montana, prior to the *Baxter* decision, a doctor who supplied a lethal drug to a patient to assist the patient to take his or her own life risked being prosecuted on a charge of culpable homicide. In Montana, charges relating to assisting suicide can only be brought where the attempt to commit suicide fails. Under Montana's law, consent can be a defence to culpable homicide if the case falls within one of four statutory exceptions. One statutory exception applies if "it [is] against public policy to permit the conduct or the resulting harm, even though consented to". By a majority of three to two, the Supreme Court of Montana held in *Baxter* that facilitated aid in dying that was provided by a doctor to a terminally ill, mentally competent adult patient was not against public policy for the purposes of Montana's exception to the consent defence. *Baxter* provides little assistance in determining the meaning of suicide in s 179 of the Crimes Act.

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[124] *Baxter v Montana*, above n 14, at [71].

[143] In my assessment, there is an important distinction between those who end their lives by taking a lethal drug and those who decline medical services and die from natural causes. There is also a distinction that can be drawn between those who end their lives by taking a lethal drug, those who are coerced into taking their own lives, and those who take their own lives for altruistic purposes.

[144] Those distinctions lead me to conclude that Ms Seales would commit suicide if she took a fatal drug supplied to her by her doctor and died from that drug. There are three features to that scenario that lead me to conclude that it would be a case of suicide. Those factors, which must be viewed in totality, are:

(1) first, Ms Seales would be intending to bring about her death; and

(2) second, Ms Seales would be acting voluntarily and not altruistically or subject to coercion; and

(3) third, the immediate cause of Ms Seales' death would be the fatal drug, not natural causes.

[145] Before Ms Seales' doctor could be convicted of an offence under s 179 of the Crimes Act in the circumstances that are contemplated by this case, Ms Seales' doctor would have to:

(1) know Ms Seales was contemplating suicide; and

(2) intentionally assist Ms Seales to commit suicide.

[146] In addition, Ms Seales' death would have to be as a consequence of the assistance provided by her doctor.[125]

[147] I conclude therefore that Ms Seales' doctor would be exposed to prosecution under s 179 of the Crimes Act if she supplied Ms Seales with a fatal drug, with the

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[125] *R v Tamatea* (2003) 20 CRNZ 363 (CA).

intention that Ms Seales would use that drug to take her own life, and if Ms Seales did so.

[148] I am reinforced in reaching my conclusions about the meaning of the relevant provisions of the Crimes Act by the following two points.

[149] First, in Canada where there is not yet legislation authorising the types of acts Ms Seales wishes her doctor to undertake, the Supreme Court of Canada has issued a declaration that has some similarities to the first of the Bill of Rights declarations sought by Ms Seales.[126] The offence provisions of Canada's Criminal Code are almost identical to the offence provisions of the Crimes Act that I have interpreted.[127] The provisions of the Canadian Criminal Code that were referred to by the Supreme Court in *Carter* were assumed to have the meaning I have given to the equivalent provisions of the Crimes Act.[128]

[150] Second, the approach I have taken to the meaning of s 179(b) of the Crimes Act is consistent with decisions of the House of Lords, the Supreme Court of the United Kingdom and the European Court of Human Rights in which it was assumed that s 2(1) of the Suicide Act 1961 (UK) has the meaning I have attributed to s 179(b).[129] It was therefore not surprising that no counsel could point to any decision in cognate jurisdictions in which provisions equivalent to the offence provisions of the Crimes Act had been interpreted in the way urged on behalf of Ms Seales.

PART III

SECTIONS 8 AND 9 NZBORA

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126 *Carter v Canada (Attorney-General)*, above n 14.

127 Compare Crimes Act 1961, s 63 with Criminal Code RSC 1985 c 46, s 14; Crimes Act 1961, s 164 with Criminal Code RSC 1985 c 46, s 226; Crimes Act 1961, s 160 with Criminal Code RSC 1985 c 46, s 222(1); Crimes Act 1961, s 179(b) with Criminal Code RSC 1985 c 46, s 241(b).

128 *Carter v Canada (Attorney-General)*, above n 14, at [1] and [13].

129 *R (Pretty) v Director of Public Prosecutions (Secretary of State for the Home Department intervening)*, above n 14; *R (Nicklinson) v Ministry of Justice*, above n 13; *Pretty v United Kingdom*, above n 14.

[151] The Bill of Rights declarations sought by Ms Seales ask me to declare that ss 179 and 160 of the Crimes Act are not consistent with the rights guaranteed to Ms Seales in ss 8 and 9 of the NZBORA in the circumstances of her case. I will first examine s 8, and then s 9.

Right not to be deprived of life

[152] The right not to be deprived of life except on such grounds as are established by law and are consistent with the principles of fundamental justice involves three components, namely:

(1) the right to life;

(2) exceptions to that right established by law; and

(3) consistency with the principles of fundamental justice.

[153] The right to life is the most fundamental of all human rights and was described by Blackstone as the first of the absolute human rights.[130] It is a right that is found in international instruments[131] and states' bills of rights.[132]

[154] In the United Kingdom, the right to life is set out in art 2 of the European Convention on Human Rights (1950),[133] and is incorporated into United Kingdom law through the Human Rights Act 1998 (UK).[134]

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130 *Blackstone's Commentaries on the Laws of England*, above n 48, at 101.

131 International Covenant on Civil and Political Rights 999 UNTS 171 (opened for signature 16 December 1966, entered into force 23 March 1976), art 6; European Convention on Human Rights (1950), art 2.

132 United States Constitution, 14th Amendment; Irish Constitution (1987), art 40.3.1; South African Constitution (1966), s 11; German Basic Law (1949), art 2.2; Canadian Charter of Rights and Freedoms (1982), s 7 and The Human Rights Act 1998 (UK), s 1 and sch 1(incorporating art 2 of the European Convention on Human Rights (1950)).

133 **Rights and Freedoms**
Article 2 Right to life
1. Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.
2. Deprivation of life shall not be regarded as inflicted in contravention of this Article when it results from the use of force which is no more than absolutely necessary:
   (a) in defence of any person from unlawful violence;
   (b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained;
   (c) in action lawfully taken for the purpose of quelling a riot or insurrection.

[155] In Canada, the right to life is in s 7 of the Canadian Charter which provides:

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

[156] Section 7 of the Canadian Charter protects a wide range of personal autonomy interests that are not expressly part of s 8 of the NZBORA. Similarly, the 14th Amendment of the United States Constitution prohibits deprivation of "liberty" without due process of law. That right goes beyond the basic right to life and engages a broad range of rights such as the right to abortion,[135] accessing contraception[136] and parental rights relating to the upbringing of children.[137]

[157] The broader nature of s 7 of the Canadian Charter and the 14th Amendment of the United States Constitution means caution is required when considering Canadian and American jurisprudence in the context of s 8 of the NZBORA.

[158] Notwithstanding the need for caution when considering cases decided under s 7 of the Canadian Charter when assessing the right in s 8 of the NZBORA, I have derived assistance from the approach taken in Canadian decisions concerning s 7 of the Canadian Charter, and in particular the judgment of the Supreme Court of Canada in *Carter*.

[159] The Supreme Court of Canada applied s 7 of the Canadian Charter and found the prohibition in the Canadian Criminal Code against assisting suicide, and the provisions of that Code which say a person cannot consent to his or her own death, were of no force to the extent that they prohibited doctors from assisting a patient to die where the patient is a competent adult who:

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134 Human Rights Act 1998 (UK), introduction.
135 *Roe v Wade* 410 US 113 (1973).
136 *Griswold v Connecticut* 381 US 479 (1965).
137 *Meyer v Nebraska* 262 US 390 (1923).

(1) clearly consents to the termination of his or her life; and

(2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the patient in the circumstances of his or her condition.

[160] The Supreme Court of Canada exercised its jurisdiction to issue a declaration of invalidity. The declaration was suspended for 12 months so as to enable the Parliament of Canada to devise an appropriate remedy.

[161] There are two features of the judgment of the Supreme Court of Canada which are relevant to Ms Seales' case, namely, the Court's analysis of the right to life, and its consideration of the principles of fundamental justice in s 7 of the Canadian Charter.

Right to life

[162] Ms Seales' reliance on her right to life in s 8 of the NZBORA may seem counterintuitive in circumstances where she is seeking assistance to die. The case presented on behalf of Ms Seales, however, mirrors the approach taken in *Carter* by the Supreme Court of Canada and involves three steps.

[163] First, the sanctity of life is one of society's most fundamental values.[138] It underpins s 8. Section 8 does not, however, require all human life be preserved in all circumstances. This was illustrated in *Shortland v Northland Health Ltd* and *Auckland Area Health Board v Attorney-General*.[139]

[164] Second, the right to life in s 8 of the NZBORA may be engaged where the law or the actions of the state impose an increased risk of death.[140]

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138 *Airedale NHS Trust v Bland*, above n 12, at 863-864 per Lord Goff.

139 *Shortland v Northland Health Ltd*, above n 51; *Auckland Area Health Board v Attorney-General*, above n 12.

140 *Carter v Canada (Attorney-General)*, above n 14, at [62]; *Osman v United Kingdom* [1998] ECHR 101 (ECHR) at [116].

[165] Third, Ms Seales has explained that she will consider taking her life earlier than she otherwise would if her general practitioner could lawfully assist her to die. In this respect Ms Seales' circumstances are identical to those addressed by the Supreme Court of Canada in *Carter*. The Supreme Court of Canada explained that the right to life was engaged when:[141]

> … the prohibition on physician-assisted dying had the effect of forcing some individuals to take their own lives prematurely, for fear that they would be incapable of doing so when they reached the point where suffering was intolerable.

[166] It is said on behalf of Ms Seales that this aspect of the reasoning in *Carter* applies with equal force to her circumstances. Applying that reasoning to the present case leads to the conclusion that the offence provisions of the Crimes Act I have interpreted in Part II of this judgment may have the effect of forcing Ms Seales to take her own life prematurely, for fear that she will be incapable of doing so when her condition deteriorates further. Accordingly, the right to life provision of s 8 of the NZBORA is engaged in the circumstances of this case.

Exemptions established by law

[167] Section 8 of the NZBORA does not guarantee the state will never deprive a person of life. Rather, s 8 guarantees the state will do so on grounds established by law.

[168] In the present context, the interference with Ms Seales' right to life is based upon grounds established by law, namely the offence provisions of the Crimes Act that I have analysed in Part II of this judgment. Those provisions were passed by Parliament and therefore constitute "grounds established by law".

Consistency with the principles of fundamental justice

[169] It is not sufficient for the interference with a person's right to life to be on grounds established by law. If s 8 is engaged, the interference with a person's right to life must also be consistent with the principles of fundamental justice. The scope of the phrase "consistent with the principles of fundamental justice" has not been

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141 *Carter v Canada (Attorney-General)*, above n 14, at [57].

determined in New Zealand. I have again found it helpful to resort to Canadian case law when analysing this aspect of s 8.

[170] Canadian cases identify three components to be considered when determining whether the principles of fundamental justice have been breached.

[171] First, the principle of fundamental justice prohibits arbitrariness and targets situations where there is no rational connection between the objective and the law. This component is referred to as "arbitrariness".

[172] Second, laws which go further than necessary breach the principle of fundamental justice when they deny the rights of individuals in a way that has no bearing on the objective of the law. In Canada, this component of the principle of fundamental justice is called "overbreadth".[142] My preference is to address this component of the principles of fundamental justice under the heading of "overly broad".

[173] Third, the principle of fundamental justice is breached if the impact of the restriction on an individual's life is grossly disproportionate to the purpose of the law in question. This is referred to as "gross disproportionality".

[174] In Canada, the onus on establishing a breach of the Canadian equivalent of s 8 of the NZBORA rests with the plaintiff. The Supreme Court of Canada in *Carter* explained:[143]

> A claimant under s 7 [of the Canadian Charter] must show that the state has deprived them of their life, liberty or security of the person and that the deprivation is not in accordance with the principles of fundamental justice.

[175] Significantly, under Canadian jurisprudence a plaintiff succeeds in establishing a breach of s 7 of the Canadian Charter if his or her individual rights under that section have been breached. This approach is compelling, and I adopt it in this judgment. Thus, the wider societal perspective required by s 5 of the

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142 *Canada (Attorney-General) v Bedford* [2013] SCC 72, [2013] 3 SCR 1101 at [112]; *Carter v Canada (Attorney-General)*, above n 14, at [85].

143 *Carter v Canada (Attorney-General)*, above n 14, at [80].

NZBORA analysis does not form part of the individual rights focus required by s 8. This point was explained in the following way in *Carter*:[144]

> … [T]he principles of fundamental justice are derived from the essential elements of our system of justice, which is itself founded on a belief in the dignity and worth of every human person. To deprive a person of constitutional rights arbitrarily or in a way that is overbroad or grossly disproportionate diminishes that worth and dignity. If a law operates in this way, it asks the right claimant to "serve as a scapegoat" … It imposes a deprivation via a process that is "fundamentally unfair" to the rights claimant.
>
> This is not to say that such a deprivation cannot be *justified* under s 1 of the Charter. In some cases the government, for practical reasons, may only be able to meet an important objective by means of a law that has some fundamental flaw. But this does not concern us when considering whether s 7 of the *Charter* has been breached.

Arbitrariness

[176] In *Chaoulli v Canada (Attorney-General)*, McLachlin CJC and Major and Bastarache JJ explained:[145]

> A law is arbitrary where "it bears no relation to, or is inconsistent with, the objective that lies behind [it]". To determine whether this is the case, it is necessary to consider the state interest and societal concerns that the provision is meant to reflect …
>
> In order not to be arbitrary, the limit on life, liberty and security requires not only a theoretical connection between the limit and the legislative goal, but a real connection on the facts … The question in every case is whether the measure is arbitrary in the sense of bearing no real relation to the goal and hence being manifestly unfair …

[177] This test has been reaffirmed by the Supreme Court of Canada in *Canada (Attorney-General) v Bedford* and *Carter*.[146]

[178] I have previously determined that the purpose of s 160(2)(a) of the Crimes Act is to protect all human life. It is not arbitrary because that is its objective. Therefore Ms Seales' rights under s 8 of the NZBORA are not limited arbitrarily by s 160(2)(a) of the Crimes Act.

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144 *Carter v Canada (Attorney-General)*, above n 14, at [81]-[82]; citing *Re B.C. Motor Vehicle Act* [1985] 2 SCR 486; *Rodriguez v British Columbia (Attorney-General)* [1993] 3 SCR 519.

145 *Chaoulli v Quebec (Attorney-General)* [2005] 1 SCR 791 at [130]-[131].

146 *Canada (Attorney-General) v Bedford*, above n 142, at [111]; *Carter v Canada (Attorney-General)*, above n 14, at [83]-[84].

[179] I have explained the dual purposes of s 179(b) of the Crimes Act in paragraph [132] of this judgment. Those purposes are broad, although not as broad as the absolute protection of all life that underpins s 160(2)(a) of the Crimes Act.

[180] The prohibition on assisting suicide in s 179(b) achieves the dual objectives which I have explained in paragraph [132]. Therefore Ms Seales' rights under s 8 of the NZBORA are not limited arbitrarily.

[181] I am reassured in reaching this conclusion by the fact the Supreme Court of Canada also concluded the equivalent of s 179 of the New Zealand Crimes Act was not arbitrary when analysed in the context of s 7 of the Canadian Charter.[147]

Overly broad

[182] In Canada, laws which infringe a protected interest under s 7 and are cast more broadly than necessary to meet the state's objective may be struck down as being overly broad, and therefore found to be in breach of the principles of fundamental justice.[148]

[183] In *Carter*, the Supreme Court explained:[149]

> … Like the other principles of fundamental justice under s 7 [of the Canadian Charter], overbreadth is not concerned with competing social interests or ancillary benefits to the general population. A law that is drawn broadly to target conduct that bears no relation to its purpose … may therefore be overbroad … The question is not whether Parliament has chosen the least restrictive means, but whether the chosen means infringe life, liberty or security of the person in a way that has no connection with the mischief contemplated by the legislature. The focus is not on broad social impacts, but on the impact of the measure on the individuals whose life, liberty or security of the person is trammelled.

[184] Applying this approach, the prohibition of murder and manslaughter in s 160(2)(a) of the Crimes Act is directed at protecting all life. Given that broad objective, it cannot be said that s 160(2)(a) of the Crimes Act overreaches its purposes, thereby breaching the principles of fundamental justice.

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147 *Carter v Canada (Attorney-General)*, above n 14, at [84].

148 Robert J Sharpe and Kent Roach *The Charter of Rights and Freedoms* (5th ed, Irwin Law Inc, Toronto, 2015) at 237.

149 *Carter v Canada (Attorney-General)*, above n 14, at [85].

[185] While the purpose of s 179(b) of the Crimes Act is not as broad as s 160(2)(a), it nevertheless is directed at the protection of human life. In light of my understanding of the purpose of s 179(b), as set out in paragraph [132] of this judgment, it is not possible for me to conclude that s 179(b) of the Crimes Act overreaches its objective. It is therefore not "overly broad".

[186] In *Carter*, the Supreme Court of Canada concluded the prohibition against aiding suicide in the Canadian Criminal Code breached the "overbreadth" component of the principles of fundamental justice because the objectives of the law prohibiting assisted suicide were able to be construed more narrowly. I am not able to construe s 179(b) in that same way, when having regard to New Zealand's different legislative framework governing this country's criminal laws relating to suicide.

Gross disproportionality

[187] The "gross disproportionality" component of the fundamental principles of justice was first referred to in *R v Malmo-Levine*.[150] A significant proportion of the Canadian jurisprudence on gross disproportionately relates to s 12 of the Canadian Charter.[151]

[188] The authors of *The Charter of Rights and Freedoms* explain that in the context of s 7 of the Canadian Charter:[152]

> Gross disproportionality describes state actions or legislative responses to a problem that are so extreme as to be disproportionate to any legitimate government interest.

[189] In *Bedford*, the Supreme Court of Canada explained that the "gross disproportionately" standard is high. The Supreme Court said:[153]

> Gross disproportionality asks a different question from arbitrariness and overbreadth. It targets the second fundamental evil: the law's effects on life,

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150 *R v Malmo-Levine* [2003] 3 SCR 571 at [160]-[161].

151 Every one has the right not to be subjected to any cruel and unusual treatment or punishment, which equates to s 9 of the NZBORA.

152 Robert J Sharpe and Kent Roach, above n 148, at 247, citing *Canada (Attorney-General) v PHS Community Services Society* [2011] 3 SCR 134 at [133].

153 *Canada (Attorney-General) v Bedford*, above n 142, at [120].

> liberty or security of the person are so grossly disproportionate to its purposes that they cannot rationally be supported. The rule against gross disproportionality only applies in extreme cases where the seriousness of the deprivation is totally out of sync with the objective of the measure. This idea is captured by the hypothetical of a law with the purpose of keeping the streets clean that imposes a sentence of life imprisonment for spitting on the sidewalk. The connection between the draconian impact of the law and its object must be entirely outside the norms accepted in our free and democratic society.

[190] Applying this approach, I conclude that the objective of s 160(2)(a) of the Crimes Act is proportionate because it achieves its fair objective of protecting all life. The connection between the impact of the law and its object are within the norms accepted in New Zealand society.

[191] Similarly, s 179(b) is not grossly disproportionate because the impact of that section and its dual objectives is well within the norms accepted by New Zealand society.

[192] In reaching this conclusion, I emphasise that I have applied a legal analysis. By focusing upon the law it may appear that I am indifferent to Ms Seales' plight. Nothing could be further from the truth. I fully acknowledge that the consequences of the law against assisting suicide as it currently stands are extremely distressing for Ms Seales and that she is suffering because that law does not accommodate her right to dignity and personal autonomy.

[193] For completeness, I note that the Supreme Court of Canada did not have to consider the "gross disproportionality" component of the principles of fundamental justice in *Carter* because it found the law against assisting suicide in Canada overreached the objectives of that law.

Right not to be subjected to torture or cruel treatment

[194] In determining Ms Seales' rights under s 9 of the NZBORA, it is necessary to determine if, in her circumstances, she is subjected to cruel, degrading or disproportionately severe treatment.

[195] The rights in s 9 can be found in international instruments[154] and states' bills of rights.[155] The commentary to the draft of what became s 9 noted its origins could be found in the Bill of Rights 1689 (UK), which prohibited any form of treatment or punishment that was incompatible with the dignity and worth of the human person.[156]

[196] The case for Ms Seales is that her suffering constitutes a form of suffering if it can be prevented, and that by depriving her the opportunity to bring her suffering to an end, the state, through the offence provisions of the Crimes Act, is subjecting her to cruel, degrading or disproportionately severe treatment.

[197] This line of reasoning was rejected by the Supreme Court of Canada in *Rodriguez v British Columbia*.[157] The appellant in that case was permanently disabled and suffering from a progressive and degenerative terminal illness. Ms Rodriguez sought an order which, if granted, would have enabled her doctor to assist her to take her own life at a time of her choosing. Ms Rodriguez's case was that the prohibition against assisting suicide in s 241(b) of the Canadian criminal code breached, among other rights, Ms Rodriguez's right not to be subjected to cruel and unusual treatment or punishment in s 12 of the Canadian Charter. Sopinka J wrote the judgment of the majority. He reasoned that before there could be "treatment" under s 12 of the Canadian Charter, there had to be some form of state control over an individual. He was of the view that a person was not subjected to "treatment" for the purposes of s 12 of the Canadian Charter if his or her suffering was due to the effects of disease. Although much of the judgment of the Supreme Court in *Rodriguez* has been overtaken by that Court's decision in *Carter*, the Court's approach to s 12 of the Canadian Charter in *Rodriguez* does not appear to have been put in issue in *Carter*.

[198] The House of Lords in *R (Pretty) v Department of Public Prosecutions* took a similar approach to that taken by the Supreme Court of Canada in *Rodriguez*. Ms

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154 International Covenant on Civil and Political Rights, above n 131, art 7; European Convention on Human Rights and Fundamental Freedoms (1950), art 3.

155 Canadian Charter on Rights and Freedoms (1982), s 12; Irish Constitution 1937, art 40.3.2.

156 Hon G Palmer *A Bill of Rights for New Zealand: A White Paper* (1985) AJHRA.6 at [10.1.62].

157 *Rodriguez v British Columbia (Attorney-General)*, above n 144.

Pretty's circumstances were in all material respects the same as those suffered by Ms Rodriguez. Ms Pretty's claim was that the Director of Public Prosecutions erred by not undertaking to refrain from prosecuting her husband if he assisted her to commit suicide, which is an offence under s 2(1) of the Suicide Act 1961 (UK). Part of Ms Pretty's case was that the decision of the Director of Public Prosecutions breached art 3 of the European Convention which prohibits inhumane and degrading treatment.

[199] The House of Lords reasoned Ms Pretty's rights under art 3 of the European Convention were not infringed. The essence of the House of Lords' reasoning was that the United Kingdom was not obliged to ensure that a competent terminally ill person in Ms Pretty's position was able to lawfully engage the services of another to assist her to take her own life. Lord Steyn said:[158]

> The word "treatment" [in art 3 of the European Convention] must take its colour from the context in which it appears. While I would not wish to give a narrow interpretation to what may constitute degrading treatment, the concept appears singularly inapt to convey the idea that the state must guarantee to individuals a right to die with the deliberate assistance of third parties.

[200] The European Court of Human Rights reached the same conclusion as the House of Lords about the effect of art 3 of the European Convention when it heard Ms Pretty's appeal:[159]

> The applicant has claimed … if he assisted [his wife] to commit suicide and the criminal-law prohibition on assisted suicide disclosed inhuman and degrading treatment for which the state is responsible as it will thereby be failing to protect her from the suffering which awaits her as her illness reaches its ultimate stages. This claim, however, places a new and extended construction on the concept of treatment, which, as found by the House of Lords, goes beyond the ordinary meaning of the word. While the Court must take a dynamic and flexible approach to the interpretation of the Convention, which is a living instrument, any interpretation must also accord with the fundamental objectives of the Convention and its coherence as a system of human rights protection. Article 3 must be construed in harmony with Article 2, which hitherto has been associated with it as reflecting basic values respected by a democratic societies. As found above, Article 2 of the Convention is first and foremost a prohibition on the use of lethal force or other conduct which might lead to the death of a human being and does not

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158 *R (Pretty) v Director of Public Prosecutions (Secretary of State for the Home Department intervening)*, above n 14, at [60].

159 *Pretty v United Kingdom*, above n 14, at [54].

> confer any right on an individual to require a State to permit or facilitate his or her death.

[201] I appreciate that the European Court of Human Rights has developed its jurisprudence since *Pretty*, but it has done so through art 8(1) of the European Convention on Human Rights.[160] Thus, in *Haas v Switzerland* and *Gross v Switzerland* the European Court of Human Rights reasoned that an individual's right to decide the way in which and the point at which his or her life should end was an aspect of the right to respect for private life within the meaning of art 8 of the Convention.[161] There is no correlation between art 8 of the European Convention on Human Rights and the provisions of the NZBORA that I have been required to consider.

[202] For completeness, I also note that in *Carter* there was no suggestion at appellate level that s 12 of the Canadian Charter was engaged. Section 12 of the Canadian Charter equates to s 9 of the NZBORA.

[203] The Canadian Supreme Court, the House of Lords and the European Court of Human Rights have all concluded that persons in Ms Seales' circumstances are not subjected to "treatment" for the purposes of s 12 of the Canadian Charter and art 3 of the European Convention because they are unable to lawfully enlist the services of others to assist them end their own life.

[204] The reasons why I have concluded Ms Seales' rights under s 9 of are not engaged in the circumstances of her case are broadly similar to the reasons given by the House of Lords in *Pretty*. I have distilled my reasons to the following three key points.

[205] First, Ms Seales' distressing circumstances are the direct consequence of her tumour, not her treatment.

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160 **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.

...

161 *Haas v Switzerland*, above n 64; *Gross v Switzerland* [2013] ECHR 429 (Section II, ECHR).

[206] Second, the treatment Ms Seales is currently receiving is designed to alleviate, to the extent that it is possible, the worst effects of her tumour.

[207] Third, the duty of the state under s 9 is not to subject persons to cruel, degrading or disproportionately severe treatment. This positive obligation is not engaged when the criminal law prohibits culpable homicide and assisting suicide even when the effect of the law is that persons in Ms Seales' position will continue to suffer from the effects of their illnesses.

[208] Like Lord Steyn, I believe the concept of cruel, degrading of disproportionately severe treatment in s 9 of the NZBORA is very inapt to convey the idea that the state must guarantee individuals in Ms Seales' circumstances a right to die through her doctor administering a fatal drug to Ms Seales, or by providing a fatal drug to enable Ms Seales to take her own life.

[209] The analysis of ss 8 and 9 of the NZBORA undertaken in Part III of this judgment leads to the conclusion that the relevant provisions of the Crimes Act as I have interpreted them in Part II of this judgment are consistent with the rights and freedoms contained in the NZBORA.[162]

Conclusion

[210] I am unable to issue any of the declarations sought by Ms Seales. In reaching this conclusion I have focused on the substantive issues rather than having resorted to the jurisdictional grounds referred to by counsel for the Attorney-General. I have taken this course because of the significance of the issues to New Zealand society raised by Ms Seales' case.

[211] Although Ms Seales has not obtained the outcomes she sought, she has selflessly provided a forum to clarify important aspects of New Zealand law. The complex legal, philosophical, moral and clinical issues raised by Ms Seales' proceedings can only be addressed by Parliament passing legislation to amend the effect of the Crimes Act. I appreciate Parliament has shown little desire to engage in

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[162] New Zealand Bill of Rights Act 1990, s 6.

these issues. The three private members bills that have attempted to address the broad issues raised by Ms Seales' proceeding gained little legislative traction.[163] However, the fact that Parliament has not been willing to address the issues raised by Ms Seales' proceeding does not provide me with a licence to depart from the constitutional role of Judges in New Zealand.

D B Collins J

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[163] Death with Dignity Bill 1995, (00-1) (Members Bill) introduced by M Laws MP on 2 April 1995; Death with Dignity Bill 2003 (37-1) (Members Bill) introduced by P Brown MP on 6 March 2003 and End of Life Choice Bill (Members Bill) placed into the Private Members Bill ballot by M Street MP in 2013 and withdrawn from the ballot in October 2013.