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Brief submitted by UNICEF Canada
to the Standing Senate Committee on Legal and Constitutional Affairs
in response to Bill C-14

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INTRODUCTION

This brief is being submitted by UNICEF Canada to the Standing Senate Committee on Legal and Constitutional Affairs in response to Bill C-14, *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*.

UNICEF Canada commends the work of the Special Joint Committee on Physician-Assisted Suicide, as well as the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying. The matters under review are complex and multi-layered, requiring much careful consideration and a measured approach, particularly when considering the potential application of new medical assistance in dying legislation to children.

UNICEF Canada is, among other things, advancing a child rights-based framework, having regard to relevant articles in the United Nations Convention on the Rights of the Child (CRC) and commentary provided by the United Nations Committee on the Rights of the Child (CRC Committee), given parliamentary and government duties to legislate in a manner consistent with the CRC.

ABOUT UNICEF

The United Nations Children's Fund (UNICEF) works in 190 countries through country programs and National Committees. UNICEF is mandated by the United Nations General Assembly to advocate for the protection of children's rights, to help meet their basic needs and to expand their opportunities to reach their full potential. UNICEF is guided by the United Nations Convention on the Rights of the Child and strives to establish children's rights as enduring ethical principles and international standards of behaviour towards children.

UNICEF is the world's leading child-focused humanitarian and development agency. Through innovative programs and advocacy work, we save children's lives and secure their rights in virtually every country. Our global reach, unparalleled influence on policymakers, and diverse partnerships make us an instrumental force in shaping a world in which no child dies of a preventable cause. UNICEF is entirely supported by voluntary donations and helps all children, regardless of race, religion or politics. The only organization named in the United Nations Convention on the Rights of the Child as a source of expertise for governments, UNICEF has

exceptional access to those whose decisions impact children's survival and quality of life. We are the world's advocate for children and their rights. For more information about UNICEF, please visit www.unicef.ca.

OVERVIEW OF UNICEF CANADA'S POSITION

UNICEF Canada acknowledges that the Supreme Court of Canada in *Carter v. Canada (Attorney General)* recognized the concept of autonomy for competent individuals, including the right to terminate one's own life with medical assistance when such individuals are faced with a grievous and irremediable medical condition causing enduring suffering. In our view, this right which is now established in law, should be extended to 'mature minors' who are competent to make end-of-life decisions for themselves, on the basis of the same eligibility criteria set out by the Supreme Court of Canada, but with additional potential safeguards.

UNICEF Canada takes the position that where medical assistance in dying is legally available to competent adults, it should also be available to competent 'mature minors', as long as it is regarded as a measure of last resort, with appropriate safeguards in place to ensure that a child is a 'mature minor' with a full understanding of its implications. In such circumstances, the 'mature minor's' entitlement to access medically-assisted death is not a human rights violation. On the contrary, it recognizes children's agency and enhances their right to self-determination.

UNICEF Canada considers that the age of majority is an arbitrary distinction for the purposes of determining competency for the making of a decision to terminate one's own life with medical assistance in dying. In our view, an absolute ban on this eligibility in the case of competent 'mature minors' would likely invite costly human rights court challenges on the basis of alleged violations of the rights guaranteed in the *Canadian Charter of Rights and Freedoms* and the United Nations Convention on the Rights of the Child. In this regard, the Supreme Court of Canada has stated in the context of the right of a minor to refuse medical treatment, in the decision of *A.C. v. Manitoba (Director of Child and Family Services)*, that "It would be arbitrary to assume that no one under the age of 16 has capacity to make medical treatment decisions" even where there may be life and death consequences. In its decision, the Court endorsed the 'mature minor' doctrine in matters of medical treatment decision-making, which emphasizes capacity and maturity over a simple age threshold.

UNICEF Canada supports the recommendation of the Special Joint Committee on Physician-Assisted Dying that there be a two-stage legislative process, with the first stage applying immediately to competent adult persons 18 years or older, to be followed by a second stage applying to competent 'mature minors', which would come into force at a date no later than three years after the first stage has been proclaimed in force. This would then allow sufficient time for informed research and a broad-based consultation period to occur, and safeguards to be put in place.

Since the Supreme Court of Canada considered evidence-based research and ethics data only in respect of adults, the same kind of research and analysis should be undertaken in respect of children before final recommendations are formulated to develop and implement medically-assisted death provisions in the *Criminal Code* that would be appropriate to the circumstances of competent children. In our view, this would be consistent with taking a cautious and balanced child rights-based approach to the question of medically-assisted death, having regard to the lessons learned in the Netherlands and Belgium where children have the right to access medically-assisted end-of-life measures in limited circumstances.

UNICEF Canada recommends a constitutional exemption for those competent 'mature minors', who are subject to a waiting period of up to one year as part of the second stage of the legislative process, before their rights to access medically assisted death are proclaimed in force. As was the case of the Supreme Court of Canada decision in *Carter*, a constitutional exemption process is required to ensure that the constitutional rights and freedoms of youth are respected, while the appropriate legislation is being developed.

UNICEF Canada considers the proposed five-year time period to start a legislative review to be excessive and favours a three-year period within which a parliamentary committee review of the enacted provisions is to be completed and a final committee report provided to Parliament. A Child Rights Impact Assessment process should be a component of this legislative review.

UNICEF Canada recommends the use of a standardized Child Rights Impact Assessment framework, during the second stage of the legislative process proposed by the Special Joint Committee on Physician-Assisted Suicide, before introducing further *Criminal Code* amendments addressing safeguards and other 'due care' considerations applicable to competent 'mature minors', as well for purposes of evaluating the impacts upon the rights and well-being of children and youth as part of the required legislated review of these new *Criminal Code* amendments subsequent to their enactment.

CARTER DECISION IS THE MINIMUM OR FLOOR FOR *CRIMINAL CODE* AMENDMENTS

In the decision of *Canada v. Carter (Attorney General)*, the Supreme Court of Canada declared sections 241(b) and 14 of the *Criminal Code* void insofar as they prohibit physician-assisted death in the following circumstances:

- a) *there is a competent adult person;*
- b) *who clearly consents to the termination of life;*
- c) *he/she has a grievous and irremediable medical condition, including an illness, disease or disability); and*
- d) *the medical condition causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.*

UNICEF Canada supports *Criminal Code* amendments to ensure a common understanding of the law and a clear and uniform framework to guide the delivery of medical assistance in dying in all Canadian jurisdictions. However, it is imperative that the new *Criminal Code* amendments are aligned with the *Carter* decision, which should be viewed as having set out the **minimum or floor** for eligibility criteria for medical assistance in dying, specifically in its reference to "a competent adult person."

Recommendation 1: That the new *Criminal Code* amendments be aligned with the Supreme Court of Canada decision of *Carter v. Canada (Attorney General)*, which should be interpreted as having set out the minimum or floor (and not an exhaustive list) for eligibility criteria for medical assistance in dying.

ELIGIBILTY CRITERIA FOR MEDICAL ASSISTANCE IN DYING SHOULD INCLUDE 'MATURE MINORS' AS PART OF A TWO-STAGE LEGISLATIVE PROCESS

In the *Carte*r decision, the Supreme Court of Canada set out as one of the criteria for physician-assisted death that the person be "a competent adult person." This component was carried over into the proposed subsection 241.2(1)(b) of the *Criminal Code*, which states:

> *Eligibility for medical assistance in dying*
>
> *241.2 (1) A person may receive medical assistance in dying only if they meet all of the following criteria:*
>
> *(a) they are eligible – or, but for any applicable minimum period of residence or waiting period, would be eligible – for health services funded by a government in Canada;*
> *(b) they are at least 18 years of age and capable of making decisions with respect to their health;*
> *(c) they have a grievous and irremediable medical condition;*
> *(d) they have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and*
> *(e) they give informed consent to receive medical assistance in dying.*

UNICEF Canada supports the positions expressed by both the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying and the Special Joint Committee on Physician-Assisted Dying that 'mature minors' should also have the right to access medical assistance in dying.

The exclusion of competent 'mature minors' from access to medical assistance in dying simply on the basis of age is an arbitrary distinction, in our view, and would likely be subject to constitutional challenge on the basis of sections 2(a) (freedom of conscience and religion); 7 (right to life, liberty and security of the person) and 15 (right to equality before and under the law

and equal protection and benefit of the law) of the *Canadian Charter of Rights and Freedom*s and section 35 of the *Constitution Act,1982* (constitutional protection to the aboriginal and treaty rights of Aboriginal peoples in Canada). If reliance was placed on the 2009 decision of the Supreme Court of Canada in *A.C. v. Manitoba (Director of Child and Family Services)*, it would also be difficult to justify why a competent 'mature minor' who has a grievous and irremediable medical condition causing enduring suffering cannot gain access to medical assistance in dying, whereas an adult person with such a condition could bring an end to his or her intolerable suffering.

In our view, the proposed requirement of a person "at least 18 years of age", as set out in clause 241.2(1)(b) of the *Criminal Code*, should be limited to the first stage of the legislative process and not be used to exclude 'mature minors' indefinitely from the ambit of autonomous decision-making in the case of medically-assisted death. Here UNICEF Canada supports the recommendation of the Special Joint Committee on Physician-Assisted Dying that there be a two-stage legislative process, with the first stage applying immediately to competent adult persons 18 years or older, to be followed by a second stage applying to competent 'mature minors' no later than three years after the first stage has come into force. This would allow sufficient time to research the issues that affect 'mature minors' more acutely and establish the necessary procedural safeguards that would protect 'mature minors' from the imposition of false information, manipulation and coercion.

Unfortunately, what we are left with is a vague commitment in the Preamble to Bill C-14 (which is non-binding) to:

> *explore other situations – each having unique implications – in which a person may seek access to medical assistance in dying,* namely situations giving rise to requests by mature minors, advance requests and requests where mental illness is the sole underlying medical condition.

RECOGNITION OF 'MATURE MINOR' DOCTRINE BY THE SUPREME COURT OF CANADA

In *A.C. v. Manitoba (Director of Child and Family Services)*, the Supreme Court of Canada considered the right of a child under 16 years of age to withhold her consent to a blood transfusion under provincial child protection legislation and spoke about the importance of striking "a constitutional balance between what the law has consistently seen as an individual's fundamental right to autonomous decision making in connection with his or her body and the law's equally persistent attempts to protect vulnerable children from harm."
In the *A.C.* case, the Court endorsed the 'mature minor' doctrine, stating that:

> *[46] The [mature minor] doctrine addresses the concern that young people should not automatically be deprived of the right to make decisions affecting their medical treatment. It provides instead that the right to make those decisions varies in accordance with the young*

person's level of maturity, with the degree to which maturity is scrutinized intensifying in accordance with the severity of the potential consequences of the treatment or of its refusal.

The Court then went on to address the arbitrariness of deciding health care decisions on the basis of chronological age:

> *[107] …it would be arbitrary to assume that no one under the age of 16 has capacity to make medical treatment decisions" and "[i]t is not, however, arbitrary to give them the opportunity to prove that they have sufficient maturity to do so.*

In the *A.C.* case, the Court concluded that the 'mature minor' doctrine applied to situations where a competent child's refusal of medical treatment could ultimately result in death:

> *In those most serious of cases, where a refusal of treatment carries a significant risk of death or permanent physical or mental impairment, a careful and comprehensive evaluation of the maturity of the adolescent will necessarily have to be undertaken to determine whether his or her decision is a genuinely independent one, reflecting a real understanding and appreciation of the decision and its potential consequences*.

Additionally, in the *A.C.* case, the Supreme Court of Canada considered the relevance of international instruments generally, and the CRC in particular, and concluded that the 'mature minor' doctrine is consistent with international human rights principles and a robust interpretation of the 'best interests of the child' standard:

> *[93] Such a robust conception of the "best interests of the child" standard is also consistent with international instruments to which Canada is a signatory. The Convention on the Rights of the Child, Can. T.S. 1992 No. 3, which Canada signed on May 28, 1990 and ratified on December 13, 1991, describes "the best interests of the child" as a primary consideration in all actions concerning children (Article 3). It then sets out a framework under which the child's own input will inform the content of the "best interests" standard, with the weight accorded to these views increasing in relation to the child's developing maturity. Articles 5 and 14 of the Convention, for example, require State Parties to respect the responsibilities, rights and duties of parents to provide direction to the child in exercising his or her rights under the Convention, "in a manner consistent with the evolving capacities of the child". Similarly, Article 12 requires State Parties to "assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child" (see also the Council of Europe's Convention for the Protection of Human Rights and Dignity of the Human Being with Regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine, Eur. T.S. No. 164, c. II, art. 6: "The opinion of the minor shall be taken into consideration as an increasingly determining factor in proportion to his or her age and degree of maturity.")*

FINAL REPORT OF THE PROVINCIAL-TERRITORIAL EXPERT ADVISORY GROUP ON PHYSICIAN –ASSISTED DYING

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In its Final Report, dated November 30, 2015, the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying determined that age was an arbitrary marker in establishing eligibility for physician-assisted death and recommended competence - rather than age - as the appropriate criterion for children to access physician-assisted dying. It said:

> *The Carter decision applies to a "competent adult person," but does not include a definition of adult. In assessing whether someone is an adult person, an arbitrary age limit such as 18 years old provides no valid safeguard. Instead, it is important that willing physicians carefully consider the context of each request to determine whether the person has the information needed, is not under coercion or undue pressure, and is competent to make such a decision.*
>
> *Competence and consent to treatment laws vary among the provinces and territories. In some cases, decisional competence is based on age, but in others, age is irrelevant to whether the patient has the legal authority to make decisions about his or her treatment.*
>
> *An ideal regulatory framework for physician-assisted dying would have uniform eligibility rules…The federal government could facilitate this by affirming that the definition of "adult"' in the context of physician-assisted dying relates to a patient's ability to give consent rather than a particular age cut-off. That is, to allow access to patients who are competent, regardless of age.*
>
> ***Recommendation 17: Access to physician-assisted dying should not be impeded by the imposition of arbitrary age limits. Provinces and territories should recommend that the federal government make it clear in its changes to the Criminal Code that eligibility for physician-assisted dying is to be based upon competence rather than age.***

REPORT OF THE SPECIAL JOINT COMMITTEE ON PHYSICIAN-ASSISTED DYING

In the Report of the Special Joint Committee on Physician-Assisted Dying, *Medical Assistance in Dying: A Patient-Centred Approach* (February 2016), the Joint Committee noted that it would be difficult to justify the exclusion of competent 'mature minors' from an entitlement to medical assistance in dying, subject to appropriate safeguards being put in place:

> *The Committee understands the concerns of many witnesses regarding the capacity of minors to understand the implications of such a serious decision. However, it is important to remember, as noted in the External Panel's report, that the Supreme Court has stated that minors have a right "to a degree of decision-making autonomy that is reflective of their evolving intelligence and understanding." Allowing competent minors access to MAID would not be eliminating the requirement for competence. Given existing practices with respect to mature minors in health care and the obvious fact that minors can suffer as much as any adult, the Committee feels that it is difficult to justify an outright ban on access to MAID for minors. As with issues of mental health, by instituting appropriate safeguards, health care practitioners can be relied upon to identify appropriate cases for MAID and to refuse MAID to minors that do not satisfy the criteria.*

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This Special Joint Committee then noted the importance of including competent 'mature minors' but in the context of a two-stage legislative process, which would come into force no later than three years after the first stage has been proclaimed in force:

> *The Committee acknowledges that a competent mature minor who has a grievous and irremediable medical condition should not be forced to endure intolerable suffering. Moreover, there are serious questions whether a restriction of the right to MAID only to competent adults would be consistent with the Charter. However, the Committee realizes that witnesses and briefs received were of differing opinions on the subject of extending the right to MAID to mature minors, and that these differences reflect a divergence of opinion among the Canadian public. After reflecting on the issue, the Committee recommends the following:*
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> ***RECOMMENDATION 6***
> ***That the Government of Canada implement a two-stage legislative process, with the first stage applying immediately to competent adult persons 18 years or older, to be followed by a second stage applying to competent mature minors, coming into force at a date no later than three years after the first stage has come into force; and***
>
> ***That the Government of Canada immediately commit to facilitating a study of the moral, medical and legal issues surrounding the concept of "mature minor" and appropriate competence standards that could be properly considered and applied to those under the age of 18, and that this study include broad-based consultations with health specialists, provincial and territorial child and youth advocates, medical practitioners, academics, researchers, mature minors, families, and ethicists before the coming into force of the second stage.***

Recommendation 2: That the proposed subsection 241.2(1)(b) of the *Criminal Code* be amended to provide that medical assistance in dying be extended to competent 'mature minors' as part of a two-stage legislative process, with the first stage applying immediately to competent adult persons 18 years or older, to be followed by a second stage applying to competent 'mature minors', which would come into force at a date no later than three years after the first stage has been proclaimed in force.

NEED FOR A FULL ASSESSMENT OF EVIDENCE-BASED RESEARCH AND MEANINGFUL CONSULTATION

UNICEF Canada takes the position that a second iteration of *Criminal Code* amendments authorizing medically-assisted death for competent 'mature minors' should be based upon a full examination of children's established human rights, evidence-based research and meaningful consultation, particularly with children and youth themselves. In this regard, UNICEF Canada supports the above-referenced recommendation of the Special Joint Committee on Physician-Assisted Dying calling for the immediate implementation of a study of the issues and safeguards

surrounding the concept of a “mature minor” and that this study include broad-based consultations.

In reaching its decision in *Carter v. Canada (Attorney General)*, the Supreme Court of Canada relied upon evidence-based research and standards of ethics that related solely to “competent adult persons”, but did not turn its mind to the scope of research data and ethical standards that would be required to define the eligibility criteria for children who wished to terminate their lives through medically-assisted death.

There is also no indication that consultation has occurred in any broad-based way that would elicit the views of children, family members, and other experts including researchers, health specialists, statutory (provincial and territorial) child and youth advocates, children’s counsel, indigenous representatives and medical practitioners. It would seem that a broader civil society – and not simply a panel of legal and medical experts – should be consulted on these highly complex matters. As well, at UNICEF Canada, we have learned that children are the experts when it comes to their own life experiences - and to forge ahead, without exercising the necessary ‘due diligence’, could lead to some unfortunate unintended circumstances for children experiencing serious health challenges and possibly for children more broadly. For example, Indigenous leaders have raised the concern about normalizing suicide.

In moving forward to ensure eligibility for competent children to access medically-assisted death in a subsequent iteration of this new legislation, it would be important, as suggested by the Canadian Paediatric Society, to establish ‘procedural due care criteria’ or safeguards to ensure that the substantive criteria, as outlined by the Supreme Court of Canada, are in fact satisfied. Examples cited are: “physician to advise patient about health condition and life expectancy; discuss request including therapeutic and palliative courses of action and consequences; have several conversations with patient to ensure durability and voluntariness of request; consultation and examination by second physician.” Other child-sensitive procedural safeguards might also include considering the degree of parental participation and advising the patient regarding access to appropriate tribunals/courts where competence is not clearly indicated. These mechanisms may need to be developed where they do not already exist. A balance must be struck between a protective oversight process and undue hurdles for children to access their rights. As well, data should be collected that identifies the rate of access by mature minors to Medical Assistance in Dying and reviewed on a regular basis by statutory provincial child and youth advocates, among others, to monitor and address any emerging concerns.

Recommendation 3: That the Parliament of Canada immediately commit to facilitating a study of the human rights, medical and legal issues surrounding the concept of ‘mature minor’ and appropriate competence standards that could be properly considered and applied to those under the age of 18, and that this study include broad-based consultations with children and youth, families, Indigenous peoples, health specialists,

statutory provincial and territorial child and youth advocates, children's counsel, medical practitioners, academics, researchers, and ethicists before the coming into force of the second stage.

CONSTITUTIONAL EXEMPTION ALLOWING COMPETENT 'MATURE MINORS' TO ACCESS MEDICALLY-ASSISTED DYING DURING THE INTERIM PERIOD PRIOR TO THE FINALIZATION OF THE SECOND STAGE OF THE LEGISLATIVE PROCESS

UNICEF Canada proposes that Bill C-14 be amended to include a constitutional exemption allowing competent 'mature minors' to access medical assistance in dying during the interim period prior to the proclamation of the *Criminal Code* provisions in the second stage of the legislative process, when those rights will be proclaimed in force.

As was the case of the Supreme Court of Canada decision in *Carter*, a constitutional exemption process is required to ensure that the constitutional rights and freedoms of youth are respected, while the appropriate legislation is being developed. In our view, competent 'mature minors' should not have to endure intolerable suffering while a period of up to one year is required to develop legislation. To enable this, interim child-sensitive safeguards should be established.

Recommendation 4: That the Parliament of Canada amend Bill C-14 to include a constitutional exemption to allow access to medical assistance in dying for those competent 'mature minors', who are subject to a waiting period of up to one year as part of the second stage of the legislative process, before their rights to access medically assisted death are proclaimed in force.

A CAUTIOUS AND BALANCED CHILD RIGHTS-BASED APPROACH TO MEDICALLY-ASSISTED DEATH

Before new *Criminal Code* provisions can be introduced to address the question of medically-assisted death for 'mature minors' on the basis of their competency to consent, there is a need to apply a cautious and balanced child rights-based approach. This balance can only be achieved through a detailed analysis of the interrelationship of the various rights in the United Nations Convention on the Rights of the Child - together with domestic legal rights established or under consideration - which Canada and the provinces/territories have committed to uphold as a result of Canada's ratification of the CRC on December 13, 1991.

Domestic legal rights that may be engaged in these end of life scenarios include sections 2(a) (freedom of conscience and religion); 7 (right to life, liberty and security of the person) and 15 (right to equality before and under the law and equal protection and benefit of the law) of the *Canadian Charter of Rights and Freedoms* and section 35 of the *Constitution Act,1982* (constitutional protection to the aboriginal and treaty rights of Aboriginal peoples in Canada). In

interpreting the *Charter*, it must be presumed to provide protection at least as great as the CRC and other international treaties. There is a presumption that Canadian statutes conform to the CRC and other international instruments and this presumption should, in our view, be a serious consideration for this Committee.

There are various rights set out in the CRC to which all children are entitled, and special measures may be required to ensure that these rights are respected, as well as actively promoted and protected. All of these rights are universal (apply to all children); indivisible and interdependent (all of these rights are dependent on one another and cannot be viewed in isolation); and inherent and inalienable (all children are born with rights that cannot be taken away from them).

There are four guiding or core principles in the CRC which are both self-standing and cross-cutting. They are article 2 (non-discrimination); article 3 (best interests of the child); article 6 (life, survival and development); and article 12 (child participation).

In relation to the issue of medically-assisted dying, a number of Convention articles are engaged (whether directly or indirectly) such as: the definition of a child (article 1); the right to non-discrimination (article 2); primary consideration of the best interests of the child (article 3); parental guidance and the child's evolving capacities (article 5); the child's right to life, survival and development (article 6); the illicit transfer and non-return of children abroad (article 11); the child's right to be heard (article 12); the child's right to freedom of expression (article 13); the child's right to freedom of thought, conscience and religion (article 14); the child's right to appropriate information (article 17); the principle that both parents have common responsibilities for the upbringing of the child (article 18); the child's right to protection from harm (article 19); the special rights of disabled children (article 23); the child's right to health and health services (article 24); the cultural rights of indigenous children (article 30); and the child's right to be protected from inhuman treatment (article 37). In order to frame a Convention–based approach, it is necessary to strike a balance between these various interdependent rights.
As mentioned, all the rights in the CRC are interdependent and equally important. This point was made by the CRC Committee in its General Comment No. 12 on the right of the child to be heard when it stated:

> *68. Article 12, as a general principle, is linked to the other general principles of the Convention, such as article 2 (the right to non-discrimination), article 6 (the right to life, survival and development) and, in particular, is interdependent with article 3 (primary consideration of the best interests of the child). The article is also closely linked with the articles related to civil rights and freedoms, particularly article 13 (the right to freedom of expression) and article 17 (the right to information). Furthermore, article 12 is connected to all other articles of the Convention, which cannot be fully implemented if the child is not respected as a subject with her or his own views on the rights enshrined in the respective articles and their implementation.*

In particular, article 12(1) of the CRC states as follows:

> 1. *States parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.*

In General Comment No. 12, the CRC Committee concluded that biological age alone cannot be determinative of the weight to be given to children's views, as they must be assessed on a case-by-case basis, having regard to the child's level of maturity.

> ***(v) "Being given due weight in accordance with the age and maturity of the child"***
>
> *28. The views of the child must be "given due weight in accordance with the age and maturity of the child." This clause refers to the capacity of the child, which has to be assessed in order to give due weight to her or his views, or to communicate to the child the way in which those views have influenced the outcome of the process. Article 12 stipulates that simply listening to the child is insufficient; the views of the child have to be seriously considered when the child is capable of forming her or his own views.*
>
> *29. By requiring that due weight be given in accordance with age and maturity, article 12 makes it clear that age alone cannot determine the significance of a child's views. Children's levels of understanding are not uniformly linked to their biological age. Research has shown that information, experience, environment, social and cultural expectations, and levels of support all contribute to the development of a child's capacities to form a view. For this reason, the views of the child have to be assessed on a case-by-case examination.*
>
> *30. Maturity refers to the ability to understand and assess the implications of a particular matter, and must therefore be considered when determining the individual capacity of a child. Maturity is difficult to define; in the context of article 12, it is the capacity of a child to express her or his views on issues in a reasonable and independent manner. The impact of the matter on the child must also be taken into consideration. The greater the impact of the outcome on the life of the child, the more relevant the appropriate assessment of the maturity of that child.*

In addition to General Comment No. 12 (2009), The right of the child to be heard, the following General Comments of the CRC Committee are also instructive and should be considered: General Comment No. 4 (2003), Adolescent health and development in the context of the Convention on the Rights of the Child;

General Comment No. 9 (2006), The rights of children with disabilities;

General Comment No. 11 (2009), Indigenous children and their rights under the Convention;

General Comment No. 14 (2013), The right of the child to have his or her best interests taken as a primary consideration (art. 3, para.1*)*; and

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General Comment No. 15 (2013), The right of the child to the enjoyment of the highest attainable standard of health (art. 24*).*

Recommendation 5: That the Parliament of Canada apply a cautious and balanced child rights-based approach and give particular attention to the United Nations Convention on the Rights of the Child when developing and introducing further *Criminal Code* amendments with respect to the issue of children's access to medically-assisted death.

THE USE OF CHILD RIGHTS IMPACT ASSESSMENTS

The process of balancing interdependent and sometimes conflicting rights under the CRC can be aided by using a structured and credible Child Rights Impact Assessment tool. In this regard, the 2012 Concluding Observations on the Convention on the Rights of the Child recommended that Canada:

> *…ensure that the principle of the best interests of the child is appropriately integrated and consistently applied in all legislative, administrative, and judicial proceedings as well as in all policies, programmes and projects relevant to and with an impact on children…*

A Child Rights Impact Assessment (CRIA) can be defined as:

> *… a systematic process or methodology of ensuring children's best interests and the potential impacts of policy change upon them are considered in the policy-making process. CRIA involves examining a proposed law or policy, administrative decision or action in a structured manner to determine its potential impact on children or specific groups of children, and whether it will effectively protect and implement the rights set out for children in the Convention on the Rights of the Child.*

In the Senate Committee's Report on Cyberbullying, the Committee provided the following probative comments on the value of Child Rights Impact Assessments:

> *…One of the main objectives of a child rights impact assessment is to ensure that while seeking to protect certain rights of children and youth, other rights are not inadvertently undermined. For example, in seeking to support the implementation of Article 19, the right to protection, it is important not to undermine rights related to education in Articles 28 and 29, as can happen when bullies are suspended or expelled from school rather than receiving supportive interventions such as counseling.*

From time to time, notwithstanding the best of intentions, legislation and policy set off unintended negative consequences for the very children they are meant to benefit. In some instances, children are not considered at all in the process, even when it is likely that a

proposed course of action will have impacts upon them. A Child Rights Impact Assessment could be effectively used to avoid or mitigate adverse impacts and enhance the benefits of policy, particularly for vulnerable children.

Recommendation 6: That the Parliament of Canada use a standardized Child Rights Impact Assessment framework, during the second stage of the legislative process proposed by the Special Joint Committee on Physician-Assisted Suicide, before introducing further *Criminal Code* amendments addressing safeguards and other 'due care' considerations applicable to competent 'mature minors', as well for purposes of evaluating the impacts upon the rights and well-being of children and youth as part of the required legislated review of these new *Criminal Code* amendments subsequent to their enactment.

NEED FOR CONSIDERATION OF GLOBAL EXPERIENCE WITH PHYSICIAN-ASSISTED DEATH FOR CHILDREN

Before completing the second iteration of the *Criminal Code* amendments enabling competent children to access medically-assisted death, it is important to consider the international perspective. In point of fact, there are very few examples of medically-assisted death being available to competent children globally. These are restricted to the Netherlands and Belgium.

In 2000, the Netherlands became the first country to allow children access to physician-assisted death. In that country, there is an age-based regime based on the presumption of evolving capacity. This means that children between 12 and 16 years of age must be able to express their views, interests and wishes in support of physician-assisted death, but still require parental consent, whereas children between 16 and 18 years of age can consent to their own physician-assisted death without parental consent, although their parents retain the right to participate in the discussions leading to a decision.

In 2015, the CRC Committee addressed the child's right to life, survival and development in its Concluding Observations to the Netherlands, expressing concern about insufficient transparency and oversight of the practice of euthanasia for children under 18 years of age, and advancing several recommendations:

> ***Right to life, survival and development***
> *28. Although there have been only five cases of euthanasia on children so far and that all cases involved terminally-ill cancer patients with no prospects of treatment, the Committee remains concerned that euthanasia can be applied to patients under 18 years of age. The Committee is also concerned about the insufficient transparency and oversight of the practice.*
>
> *29.* ***The Committee recommends that the State party:***
> ***(a) Ensure strong control of the practice of euthanasia towards underage patients;***

(b) Ensure that the psychological status of the child and parents or guardians requesting termination of life are seriously taken into consideration when determining whether to grant the request;
(c) Ensure that all cases of euthanasia towards underage patients are reported, and particularly included into annual reports of the regional assessment committees, and given the fullest possible overview; and
(d) Consider the possibility of abolishing the use of euthanasia towards patients under 18 years of age.

In 2002, Belgium became the second country in the world to legalize physician-assisted death after the Netherlands. With that enactment, only people in Belgium who were 18 or older and in a "hopeless medical condition" could request to die. Children aged 15 and over who were "legally emancipated" from their parents could also request to undergo physician-assisted death. However, in 2014, Belgium amended its legislation and became the first country in the world to remove any age restrictions on physician-assisted death.

Under these amendments, a child of any age can be helped to die, but only under strict conditions: he or she must be terminally ill, and deemed to "be in a hopeless medical situation of constant and unbearable suffering that cannot be eased and which will cause death in the short term." The child must be able to request physician-assisted death themselves and demonstrate they fully understand their choice. The request will then be assessed by teams of doctors, psychologists and other care-givers before a final decision is made with the approval of the child's parents. Unlike the case of the Netherlands, these new provisions have not yet been the subject of commentary by the CRC Committee and Belgium's next review is not planned until 2017/2018.

The Child Rights Information Network (CRIN) has reported that in the case of *ASBL "Jurivie" et al. v. Belgium*, three pro-life organizations brought a challenge in 2015 before the Constitutional Court of Belgium against the Belgian 2014 Act, arguing that legalized euthanasia for children is incompatible with the Belgian Constitution, the CRC and the European Convention on Human Rights. However, the Court dismissed the challenge to the legality of the 2014 amendment, holding that the law includes enough safeguards and guidelines to guarantee respect for children's rights. According to the Court, allowing children to end their lives with the help of doctors, as long as the safeguards have been respected, is not incompatible with the Belgian Constitution, the CRC and the European Convention on Human Rights. CRIN then went on to state its own view that "this decision is consistent with the CRC. Where it is regarded as a measure of last resort and appropriate safeguards are in place to ensure that the child has a full understanding of its implications, euthanasia is not a human rights violation. On the contrary, it recognizes children's agency and enhances their right to self-determination."

Recommendation 7: That the Parliament of Canada consider the experience of those countries that have legalized medically-assisted death for children, before developing

and introducing further *Criminal Code* amendments as part of the second-stage legislative process to legalize such practices for Canadian children who qualify as competent 'mature minors'.

REVIEW OF NEW *CRIMINAL CODE* AMENDMENTS AFTER FIVE YEARS

Section 10 of Bill C-14 sets out the procedure for the review of these new *Criminal Code* amendments in the following terms:

> ***Review by committee***
> *10(1) At the start of the fifth year after the day on which this Act receives royal assent, the provisions enacted by this Act are to be referred to the committee of the Senate, of the House of Commons or of both Houses of Parliament that may be designated or established for the purpose of reviewing the provisions.*
>
> ***Report***
> *(2) The committee to which the provisions are referred is to review them and submit a report to the House or Houses of Parliament of which it is a committee, including a statement setting out any changes to the provisions that the committee recommends.*

In our view, the creation of a committee in five years time to commence a review of the provisions of the Act and propose any changes is an excessive period of time and should be abridged to a three year period for both the completion of the review and the preparation of a report. It is also a concern that there is no commitment for a date for reporting back in the current version of Bill C-14.

As mentioned elsewhere in this written submission, the period established for a legislative review would provide a perfect opportunity to use a Child Rights Impact Assessment framework.

Recommendation 8: That section 10 of Bill C-14 be amended to provide that a legislative review of the enacted provisions be completed by a designated parliamentary committee and a report provided by that committee to Parliament within three years of proclamation, with the immediate creation of a parliamentary review committee upon proclamation of such enacted provisions.

CONCLUSION

In summary, UNICEF Canada recognizes the complexity of achieving the correct balance between the preservation of individual autonomy and the protection of the life and health of vulnerable persons when developing legislation to support medical assistance in dying for the first time in Canada. This is reflected in the multitude and variety of principles set out in the Preamble to Bill C-14.

We have carefully reviewed the text of Bill C-14 and have proposed a number of amendments to Bill C-14, which we trust will be helpful in this Committee's deliberations.

Respectfully submitted on behalf of UNICEF Canada by:

"MMB"

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APPENDIX 'A' – LIST OF RECOMMENDATIONS

Recommendation 1: That the new *Criminal Code* amendments be aligned with the Supreme Court of Canada decision of *Carter v. Canada (Attorney General)*, which should be interpreted as having set out the minimum or floor (and not an exhaustive list) for eligibility criteria for medical assistance in dying.

Recommendation 2: That the proposed subsection 241.2(1)(b) of the *Criminal Code* be amended to provide that medical assistance in dying be extended to competent 'mature minors' as part of a two-stage legislative process, with the first stage applying immediately to competent adult persons 18 years or older, to be followed by a second stage applying to competent 'mature minors', which would come into force at a date no later than three years after the first stage has been proclaimed in force.

Recommendation 3: That the Parliament of Canada immediately commit to facilitating a study of the human rights, medical and legal issues surrounding the concept of 'mature minor' and appropriate competence standards that could be properly considered and applied to those under the age of 18, and that this study include broad-based consultations with children and youth, families, Indigenous peoples, health specialists, statutory provincial and territorial child and youth advocates, children's counsel, medical practitioners, academics, researchers, and ethicists before the coming into force of the second stage.

Recommendation 4: That the Parliament of Canada amend Bill C-14 to include a constitutional exemption to allow access to medical assistance in dying for those competent 'mature minors', who are subject to a waiting period of up to one year as part of the second stage of the legislative process, before their rights to access medically assisted death are proclaimed in force.

Recommendation 5: That the Parliament of Canada apply a cautious and balanced child rights-based approach and give particular attention to the United Nations Convention on the Rights of the Child when developing and introducing further *Criminal Code* amendments with respect to the issue of children's access to medically-assisted death.

Recommendation 6: That the Parliament of Canada use a standardized Child Rights Impact Assessment framework, during the second stage of the legislative process proposed by the Special Joint Committee on Physician-Assisted Suicide, before introducing further *Criminal Code* amendments addressing safeguards and other 'due care' considerations applicable to competent 'mature minors', as well for purposes of evaluating the impacts upon the rights and well-being of children and youth as part of

the required legislated review of these new *Criminal Code* amendments subsequent to their enactment.

Recommendation 7: That the Parliament of Canada consider the experience of those countries that have legalized medically-assisted death for children, before developing and introducing further *Criminal Code* amendments as part of the second-stage legislative process to legalize such practices for Canadian children who qualify as competent 'mature minors'.

Recommendation 8: That section 10 of Bill C-14 be amended to provide that a legislative review of the enacted provisions be completed by a designated parliamentary committee and a report provided by that committee to Parliament within three years of proclamation, with the immediate creation of a parliamentary review committee upon proclamation of such enacted provisions.

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APPENDIX 'B' – REFERENCES AND SELECTED BIBLIOGRAPHY

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