Minister for Health
and Social Services

Government of Jersey
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Deputy Louise Doublet
Chair, Health and Social Security Scrutiny Panel
BY EMAIL

04 December 2025

Dear Chair

RE: Review into the Assisted Dying legislation: Public Review Hearing follow-up questions

Thank you for your letter dated 26 November. Responses to your questions are set out below.

End-of-Life Care

1. Has the Minister considered whether there will be a formal route for appeals or challenges from family members in relation to decisions made under the proposed end-of-life-care law, particularly where there may be disagreement about eligibility, care planning or access to services?

P73/2025 asks the Assembly to agree, in-principle, that the Minister should be required by law to provide for end-of-life care in Jersey, and that a draft law should be developed to that effect.

In the accompanying report to P73/2025, I set out a broad overview of some of the anticipated features of a draft law; and explain that it would be developed in consultation with the public and professional stakeholders.

At this stage, there has not been full consideration of what decisions may be made under the proposed draft law (or consequently appeals or challenges to such decisions), however, if the Assembly votes to accept P73, I will commit to ensuring these matters form part of the consultation process.

a. In terms of the definition of 'close relative' in this context, and elsewhere in the law, why does part (b) of this definition only include partners who live together? In practice, how would this impact partners where one resides in a care home for example?

'Close relative' is defined in draft assisted dying law. It is not known, at this stage, if a mirroring definition will be required in the draft end-of-life law.

The matters to which 'close relative' relates in the draft assisted dying law are:

- people who may / may not act as a witness to the second request (Article 17)
- a professional's declaration of interests in relation to the individual requesting assisted dying (Article 21), and / or the independent assessment doctor's relationship to the coordinating doctor (Article 22)

Article 17 (7) (c) sets out that any person that is likely to benefit financially or in any significant way from an individual's death cannot act as a witness at Step 4. Whilst this would, in practice, likely exclude all non-cohabiting partners, the law does not explicitly extend the definition of close relative to include non-cohabiting partners.

I thank the Panel for highlighting this matter, and having given it consideration, I intend to lodge a small amendment to the law to clarify that the definition of 'close relatives' should include partners in a relationship which is akin to a marriage/civil partnership, but would include both partners who live together and those who do not.

Articles 21 & 22 for the purposes of professionals declaring their interests, the law as drafted, would have the effect of including consideration of non-cohabiting partners, given that under Articles 21 and 22, the interests review officer is required to consider:

- at 21 (2) (c): any disclosed interests in relation to the professional and individual requesting assisted dying, that may be or be seen to conflict with the individual's interests [i.e. this would include non-cohabiting partners]; and
- at 22 (2) (b): any form of personal relationship between the independent assessment doctor and coordinating doctor that might be seen to conflict with their independence [i.e. this would include non-cohabiting partners].

b. How would this definition, if changed, impact articles 17, 21 and 22, and any others that are relevant?

Changing the definition of 'close relative' to include non-cohabiting partners would likely have limited practical effect but it would serve to provide absolute clarity over who may act as a witness at Step 4, and where disclosures of interest would be considered as a conflict of interest at Articles 21 & 22. For this reason, I am very happy to bring forward a clarifying amendment.

2. Can the Minister clarify how the proposed end-of-life care law will interact with the draft Assisted Dying law, particularly in ensuring that no individual feels compelled to choose an assisted death due to inadequate access to palliative care?

a. the proposition refers to the importance of 'real choice', how will this principle be safeguarded in practice?

As per my response to question 1 above, the detailed development of the end-of-life care law will take place after an in-principle decision on P73 is made by the Assembly. However, as you set out, the assisted dying proposals have a clear policy principle that no person should seek an assisted death on the basis they cannot, or believe they cannot, access high quality end-of-life care – and it is this principle of 'real choice' that helped shaped my commitment in the development of an end-of-life care law (i.e. the existence of an end-of-life care law will, in itself, safeguard the principle of real choice). Furthermore, the principle will be safeguarded via:

- the provisions in the proposed end-of-life care law which, subject to the Assembly's agreement, will place a duty on the Minister to provide end-of-life care
- the work of the End-of-Life Care Partnership which is evidenced to be delivering improvements to end-of-life care
- the decision of the States Assembly to invest an additional £3m in end-of-life care.

The Panel will also note that the Assisted Dying law places a very clear duty on assessing doctors to ensure that in the individual's request for an assisted dying is informed (as per Article 20), which includes them being informed about the: *options for care and treatment that are available to them, and the likely outcomes, including options*

(i) that are end-of-life or otherwise palliative; or
(ii) that the person may have previously discounted or discontinued

i.e. in addition to the proposed end-of-life care law and the work of the End-of-Life Care Partnership providing for 'real choice', the draft assisted dying law works to ensure that individuals are fully informed as to their choices.

b. are periodic reviews planned to ensure this continues?

The quarterly review of the End-of-Life strategy implementation remains in place. In addition, there are quarterly commissioning reviews with providers commissioned to deliver the services which are set up to ensure that service specifications are delivered.

Furthermore, the draft assisted dying law makes explicit provisions that identify any deviation from the principle of real choice:

a. Article 7 provides that the coordinating doctor must, before approving a person's request for an assisted death, ensure that all previous steps have been complied with. This means, the Coordinating Doctor must ensure that the individual has been fully informed as to their end-of-life care choices.

b. Article 94 provides that the Review Panel must review every assisted death that is carried out (and assisted dying processes that ended before an assisted death, if requested to do

so by the Committee) with those reviews allowing for identification of any failings to ensure the person was fully informed as to their end-of-life care choices.

3. The Jersey Care Commission has suggested that a requirement of palliative care specialists in the assessment process could strengthen the Draft Law and align Jersey's approach with practices in other jurisdictions. Has the Minister considered explicitly requiring the involvement of palliative care specialists in the assessment process for assisted dying, to help ensure patients receive comprehensive and informed support?

As noted in the recent Panel Hearing, the Jersey Care Commission had not previously communicated to me the suggestion of explicitly requiring palliative care specialists to be involved in the assessment process, despite the Commission having been extensively engaged in the policy and legislation development process.

That said, it is nevertheless the case that consideration was given to this matter. As articulated in the Hearing, the draft law highlights that a person requesting an assisted death must have access to relevant information on all their care and treatment options, including palliative and end-of-life care (see Question 4 below for more detail). However, the law does not mandate that the person must have a palliative care assessment on the basis that:

- access to palliative care should be a patient-held choice, something that is offered but not mandated
- mandatory palliative care assessments may not be appropriate in all circumstances – for example where a person has a life expectancy of less than 14 days and has already received / are receiving significant end-of-life care and palliative support from palliative care specialists.

It is important to note that the draft law also provides for an extended team whose members support an individual's assisted dying process. Extended team members may include palliative care practitioners, including doctors and nurses.

Furthermore, as previously stated, the majority of people who have assisted deaths (in jurisdictions where assisted dying is already permitted) are in receipt of palliative and end-of-life care and continue to be in receipt of that care until the time of their assisted death – thus negating any mandatory palliative care assessment.

4. The Jersey Care Commission notes that jurisdictions with defined referral points help embed palliative care as a core component of end-of-life decision-making. Can the Minister outline what provisions are in place within the Draft Law to ensure clear referral pathways to palliative care services are maintained and integral to the overall process?

The draft assisted dying law seeks to balance the policy principles of a person making an informed choice about an assisted dying decision and a patient's choice about the manner and timing of their death.

The draft law provides that:

- an individual is only eligible for an assisted death if they meet the eligibility criteria, including the decision criteria, which state that their decision for an assisted death must be informed [see Article 2 (4) (b) (iv)]
- an assessing doctor may only approve an individual as eligible for assisted dying if they are satisfied that their decision is informed [see Articles 4 (2) (b) and 5 (2) (e)]
- Articles 28 and 29 give further clarification as to what an assessing doctor must do to ensure they are satisfied the person is informed. Article 29 (2) sets out the person must be informed about:
    - the physical condition that is expected to cause their death;
    - the expected course of the condition;
    - the options for care and treatment that are available to them, and the likely outcomes, including options –
        - that are end-of-life or otherwise palliative; or
        - that the person may have previously discounted or discontinued

- In providing the information set out in Article 29 [as required at Articles 4 (2) (b) and 5 (2) (e)], the assessing doctor may seek a relevant opinion from another professional; and must seek a relevant opinion if it is needed for them to make a determination of eligibility. This means that:
    a. if the assessing doctor has expertise in end-of-life care, they may not require another professional's opinion to make a decision as to whether the person is sufficiently informed about their care options, but
    b. if the assessing doctor does not have expertise in end-of-life care and they are unable to make a decision as to whether the individual is sufficiently informed about their care options, the law requires that they must seek a relevant opinion of an appropriate professional – for example a palliative care specialist.

- Article 31 provides detail on how relevant opinions are sought, and set out that a relevant opinion may be:
    - based on the that professional's experience or expertise (*so in this example, the palliative care specialist may provide general information about options for palliative or end-of-life treatment*); and/or
    - based on an examination of the person (*so in this example the palliative care specialist would meet with the individual and explore their end-of-life options, based on their specific situation and prognosis*)

In addition, Article 54 provides that one or more of the independent members of the Assurance and Delivery Committee would include:

- a representative of a service that provides palliative and end-of-life care in Jersey; and
- a patient or carer representative with experience of palliative and end-of-life services

This safeguard ensures the continued prioritisation of ensuring assisted dying requests are based on 'real choice', as opposed to a lack of adequate alternatives.

5. What measures are in place to evaluate the overall effectiveness of the End-of-Life Partnership's work in delivering the aims of the Strategy, and how will future improvements be identified and implemented?

As set out in the addendum to P65/2024 the End-of-Life Partnership has provided a report that evidences the current quality and availability of palliative and end-of-life care in Jersey. A review of the current provision is being undertaken in Q2 2026, which will result in an updated strategy and action plan covering 2027 to 2031, which will include continued monitoring of access to end-of-life care, including for those requesting assisted dying, when the Service is operational.

In considering the work of the End-of-Life Partnership is it important to reflect the fact that its members (which include Jersey Hospice Care, Family Nursing and Home Care, Jersey Doctors on Call, Primary Care Board, Jersey Care Federation, LV Care Group, Macmillan Jersey in addition to others) are committed to the provision of compassionate, high quality end-of-life care, and to the continuous improvement of that care. The commissioning team facilitates this partnership as part of its service review, identifying gaps and opportunities for improvement, and introducing changes where needed.

Public Awareness

6. How have you assessed current public awareness and understanding of the proposed assisted dying service among those most directly affected (including people living with terminal illness and their families), and what evidence can the Minister provide about awareness levels to date?

Given the sensitive nature of the topic, I have not requested my officers to specifically assess awareness and understanding of the proposed assisted dying service amongst people who are living with a terminal illness.

It is the case that, whilst we have not sought to specifically engage with terminally ill people, some terminally ill people who have attended our public meetings, responded to our public surveys and have spoken to the media about assisted dying – hence we know that some want the option of an assisted death (as well as those who do not). To actively speak with them about a law which is not approved, and which will likely come into effect after their deaths, feels inappropriate.

Work has, however, been undertaken by officers during the lodging period to inform the public about the details of the draft law. This has included a series of public meeting.

a. Given the offence provisions around "advertising or promoting" assisted dying, can the Minister clarify whether a practitioner could face liability for initiating a conversation about the service?

As discussed during our recent Hearing, the draft law creates an offence of "advertising or promoting" assisted dying with the intention of persuading or encouraging anyone to have an assisted death or by intentionally providing information about assisted dying that goes beyond what is permitted by the law.

It is not an offence for a professional to initiate a conversation about the assisted dying service, or to provide information about assisted dying providing, the information is about

(i) the availability of assisted dying and related services
(ii) where more information on assisted dying can be found
(iii) about the professional's role in assisted dying; or
(iv) that supports awareness and understanding of assisted dying

However, a professional may commit an offence if, during a conversation about assisted dying with a patient, the professional actively encourages or persuades the patient to request assisted dying. Doing so may be considered a breach of Article 78 (3)(b) and an offence under Article 50 or, depending on the facts and circumstances of the case, may be considered an offence under Article 45 (offence to coerce a person to request assisted dying)

As required by the draft law, the Committee will develop Appropriate Conversations Guidance, which will set out the circumstances where it is (or is not) appropriate to initiate a conversation about Assisted Dying. As set out in the addendum to P65 the guidance on Appropriate Conversations will:

- set out the circumstances in which it would not be appropriate to raise the issue of assisted dying with a patient;
- confirm the limited circumstances where it may be appropriate for professional (doctor) to raise the subject of assisted dying with a patient (e.g. when discussing all care and treatment options, including palliative care, with a patient with a terminal diagnosis)

The addendum to P65 also specifies that the assisted dying training, to be made available to all on-island health and care professionals, will cover what is and is not appropriate when discussing assisted dying with patients. The training and guidance will also provide scenarios of where an offence may be committed.

b. What comment can you make on the balance between it being an offence to advertise the service to islanders, and islanders having sufficient awareness that the service exists, particularly in the light of the human rights implications outlined on p119 of the proposition?

My response below assumes that you are referring to the following paragraph of the Human Rights Note as prepared by law officers:

Where a possibility is available for individuals to seek assisted dying, there must be comprehensive and clear guidelines governing the right to obtain assistance, the absence of which will violate the right to personal autonomy under Article 8

The Human Rights Note says that there must be clear and comprehensive guidelines about the provision of assisted dying and, whilst the law as drafted seeks to prevent the promotion and advertising of assisted dying for the purpose of persuading or encouraging anyone to have an assisted death, it does not prevent information about assisted dying from being provided in writing or by broadcast, in the way that accords with Article 78 (i.e. the draft law allows for a balance to be struck between the offence of 'advertising and promoting with the intent of encouraging, and the required to provide information to support awareness of the service.)

- The information made available about assisted dying will include information about:
    - the criteria for assisted dying
    - steps of the assisted dying process
    - information about the Service, including its contact details
    - the appeals process
    - how someone may complain about the Service

c. How will the law distinguish between appropriate clinical discussion and prohibited promotion, particularly in the context of ensuring equal access?

The law already distinguishes between these two things as it prohibits advertising and promotion, with the intention of persuading or encouraging anyone to have an assisted death, whilst explicitly permitting the provision of the following information:

- the availability of assisted dying and related services
- where more information on assisted dying can be found
- about the professional's role in assisted dying; or
- that supports awareness and understanding of assisted dying

The mandatory training to be provided to Assisted Dying Practitioners, the optional training on Appropriate Conversations to be made available to all health and care professionals, and the associated Appropriate Conversations Guidance will set out further detail.

Decisions on prosecutions of offences committed under the law, as ever, will ultimately be a decision for Law Officers.

d. How will you monitor and evaluate awareness of the service and access to information about it, particularly for those who need assistance with communication?

This work will be included in the implementation phase workstream on public awareness of assisted dying service. As I stated in the Hearing, I will ensure that information about assisted dying is also produced in accessible formats, as I have done to-date, during the consultation phases of this work.

Doctors based in the UK

7. Is the Minister aware of any UK doctors who work between the UK and Jersey, i.e., provide care in Jersey rather than treating Jersey residents in the UK, and if so, how will they be eligible to opt in to the AD service?

There are doctors who work both in the UK and in Jersey. Those doctors are all required to register with the Jersey Care Commission. Those doctors are not prohibited from registering as an assisted dying practitioner they meet the criteria set out in the draft law under Article 80.

a. What provisions will apply to doctors who treat patients in the UK but are restricted from treating those who have requested assisted dying?

I am not sure of the restrictions this question refers to.

Currently, neither UK law nor the draft assisted dying law would prevent Jersey patients, who have requested an assisted death, from being treated in the UK where that treatment relates to their existing medical condition.

There is, however, potential for doctors to be found to have committed the offence of encouraging or assisting suicide (in accordance with Section 2 of UK's Suicide Act 1961) if, whilst in the UK, they provide a relevant professional opinion as part of an assisted dying assessment. This risk is described in the BMA's submission to the Panel.

Hence, the draft assisted dying law sets out that any assisted dying assessments or relevant opinion must be carried out in Jersey (i.e. any UK-based doctor providing a relevant professional opinion would need to do so whilst physically in Jersey). The Ministry of Justice have confirmed that the UK Suicide Act 1961 does not have extra-territorial jurisdiction, so any participation in assisted dying on Jersey soil would not be considered an offence under Section 2 of that Act.

Waiver of the requirement of future capacity

8. In Canada a waiver may also cover individuals who wish to take a sedative prior to AD to treat anxiety etc before the AD practitioner arrives, and so capacity may be lost due to drugs rather than illness. This scenario is not addressed by the Jersey approach, and so has this been discussed and if not, should this be considered?

The waiver of requirement for future capacity under the draft law can only be made by an individual who has a terminal illness, who is expected to die within the prescribed timeframe and whose request for an assisted death has been approved. This means, the request must be voluntary (i.e. free from coercion), clearly expressed, settled and informed, with the assessing doctors having satisfied themselves as to the nature of the person's request at multiple stages in the process.

If that individual decides, at Step 6, to both make a final request for assisted dying and to waive the requirement for future capacity (and they have the capacity to make both those decisions at point in time) the scenario you describe is permissible under the draft law - i.e. the person may have taken a sedative prior to the arrival of the administering practitioner or have drunk alcohol (either with the express purpose of managing their anxiety or managing their pain), they may then have lost capacity and, because the waiver is in place, the Administering Practitioner may then proceed to administering the approved drugs if the person shows no signs of resistance.

There is no compelling reason for prohibiting a person from taking a sedative or drinking alcohol before an assisted dying, given that the person has been found to have a voluntary, settled and informed wish for an assisted death. It is acknowledged that it is theoretically possible that the person may change their mind in between taking the sedative / alcohol and the administration of the approved drugs but the robustness of the assisted dying process up until that point is sufficient to effectively mitigate, if not entirely negate that risk.

9. From a legal and ethical standpoint, how does the Minister justify the inclusion of a waiver that potentially removes an individual's right to withdraw consent at the final stage?

As set out above, the draft law only permits use of the waiver if the person has been approved for an assisted death, following a robust assessment process which during which assessing doctors must, on multiple occasions, have satisfied themselves that the person' request for an assisted death is voluntary, clearly expressed, settled and informed decision to have an assisted death. If there are any doubts about the settled nature of the individual's request at any stage in the process, they cannot have an assisted death.

The draft law is also clear that even if the waiver is in place, where an individual shows any signs of refusal or resistance, the practitioner must not proceed with the assisted death.

Law officers have confirmed they are of the opinion that the provisions of the draft law, including the waiver, are compatible with the European Convention on Human Rights.
As highlighted by Dr Grose during the recent Scrutiny Hearing, where an individual's condition has deteriorated to the point where they no longer have capacity, it would not be anticipated that they would have the required mental function to change their mind about a previous decision they had made (i.e. they would not have the mental functioning to decide that they want to withdraw consent):

"there would be a very fair assumption that if somebody had continued to clinically deteriorate to the point in which they could not speak and they lose capacity and that capacity does not return, that associated with that deteriorating function would be a deteriorating mental function. It would be very unlikely that they would maintain cognitive ability to be making a different decision in the context of their body failing and fading to the degree in which they could not verbalise or recognise around what was happening. [The questioner's] assumption here is saying that somebody would maintain the cognitive ability to change their mind despite losing capacity and the ability to communicate. From my perspective, if somebody was deteriorating to the point in which they could not talk to me, then there is a very strong assumption that they would not have the cognitive ability to be thinking about such a complicated topic and making a different decision by the default of how poorly they were in losing the capacity that they lacked."

The issue of the waiver was discussed extensively during the policy development phase from an ethical perspective, i.e. the ethical challenges of a practitioner not being able to administer the approved drugs where that practitioner was satisfied that the person wanted to have an assisted death – in order to maintain control and dignity and / or release themselves from pain and suffering - but had lost capacity in days / hours before having that assisted death. This included discussions with assisted dying practitioners in jurisdictions where assisted dying is permitted - but there is no waiver - and the associated distress caused to loved ones, in addition to the person, of not proceeding to administration contrary to the understood and clearly expressed wishes of the person.

Having weighted up all these factors and having reflected on the extensive safeguards provided in the draft law, I am of the view that the inclusion of a waiver is both legally and ethically appropriate.

a. What legal safeguards will ensure that this does not conflict with fundamental rights or principles of autonomy?

As set out above, the draft law is clear that when choosing to sign a waiver, the person must also make a final request for assisted dying. The care planning guidance will provide explicit detail on the conversations the administering practitioner must have with the individual to ensure they a clear of the full implications of making a final request for assisted dying and either choosing to sign, or not sign, a waiver.

The principle of autonomy underpins the assisted dying law, which provides a person a degree of the autonomy as to the timing and manner of their death, with the waive respecting that autonomous decision.

10. Is the Minister confident that there are sufficient safeguards in place to mitigate ethical concerns regarding the waiver?

I am confident that there are sufficient safeguards to mitigate against the ethical concerns associated with the waiver. I am satisfied that, on balance, the provision of a waiver is more ethically sound than not providing for a waiver.

a. The proposed waiver appears to remove the individual's right to withdraw consent at the final stage of the process. How does the Minister reconcile this with the principle that a person should be entitled to change their mind at any point?

The proposed waiver does not remove the individual's right to withdraw their assisted dying request at any stage of the process. An individual who has signed a waiver may withdraw their request at any point immediately prior to the administration of the approved drugs. They may do so verbally, or by showing signs of refusal or resistance. This includes both individuals who have lost capacity and retained capacity.

b. How confident is the Minister that someone who has signed a waiver will retain the ability to opt out, even after signing? What mechanisms will ensure this?

I am confident this is the case, see response to questions above.

c. What evidence does the Minister have regarding the rate at which individuals change their mind at the end of the assisted dying process, and how will this inform safeguards around the waiver?

It is known from other jurisdictions that a proportion of people who have been approved for an assisted death do not proceed to having an assisted death (28% in Western Australia). This includes people who die before their assisted death, people who simply choose not to exercise their approval (sometime because the knowledge that they can be released from their pain / suffering at a time of their choosing is sufficient) and people who change their mind in the days leading up to the assisted death.

The draft law brings forward extensive reporting requirements, including the requirement to report on the numbers of people who withdrew their request for assisted dying and the step in process as which they do so. Hence, this information will be known in future.

d.Is there a risk that an individual who has signed a waiver and then changed their mind, but is unable to communicate this, could have their life ended against their will? What safeguards will prevent the risk of non-communicated refusal?

As stated, the Administering Practitioner cannot proceed to administer the approved drugs, regardless of whether the individual has signed a waiver, if there are any signs of refusal or resistance. Refusal and resistance can be communicated via gestures as well as being communicated verbally.

As set out above, if an individual has deteriorated to the point, they do not have capacity and are not able to communicate, even by gestures, there is a very strong assumption they would not

have the cognitive ability to decide they do not wish to proceed with their previously stated intention of having an assisted death.

If a person does not communicate a refusal, either by words or gestures, no person can know whether or not the person is in fact refusing. No safeguard can prevent the risk of 'non-communicated refusal'. That said, any person who has an assisted death will have gone through an extensive process of request, assessment and approval and will have had to reiterate their wish for an assisted death at multiple stages in the process.

Psychological and Spiritual Support

11. In light of the Royal College of Psychiatrists' submission to the Panel, what provision will be made for psychological and spiritual support for individuals throughout the assisted dying process?

a. Will this be in a form which is accessible to individual of any religion or belief, or none?

Article 78 of the draft law requires the assisted dying service to arrange for the provision of support related to assisted dying for:

- individuals and their connected people (i.e. family and carers); and
- professionals involved in the process - assisted dying practitioners, care navigators and certifying doctors

The support provided will include psychological support (including counselling) as well as the provision of spiritual support for those with any religion, belief of none. Detail of the provision of support will be developed during the implementation phase.

Concerns raised by the British Medical Association and the General Medical Council in their submissions

As discussed at the recent Scrutiny Hearing, the comments provided by the BMA and GMC were on an earlier version of the law, which has subsequently been amended in response to BMA and GMC feedback.

My officers are currently in the process of confirming with the BMA and GMC that the final draft of the law, as lodge, addressed their concerns and, in the event there are outstanding matters, I will consider addressing these via an amendment to the draft law before it is debated.

I will update the Panel once we have received feedback.

Legal provision that establish the obligation to explore all palliative care options

I note that the Panel asks for information about the legal provision that establishes the obligation to explore all palliative care options. This information is set out above.

I trust the above is of assistance to the Panel.

Yours sincerely

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