Review of Assisted Dying Legislation

Assisted Dying Review Panel

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Chair's Foreword

Assisted dying is one of the most sensitive and ethically complex issues to be brought before the States Assembly. It engages deep questions of autonomy, dignity, compassion, vulnerability, together with robust safeguards. The Assisted Dying Review Panel has approached this scrutiny review with great care, recognising both the historic nature of the proposals and the importance of ensuring that any future framework for assisted dying in Jersey is safe, ethical, and grounded in the principles agreed by the States Assembly.

Our task has been to examine whether the detailed legislative scheme brought forward by Ministers gives effect to the principles adopted by the Assembly through P.18/2024; whether safeguards are adequate; and whether the law would operate safely, transparently, and fairly for all Islanders. Throughout this review we heard from clinicians, regulators, charities, disability groups, Diversity Equity and Inclusion (DEI) experts, academics, legal experts, care providers, and members of the public. Their evidence was thoughtful, often deeply personal, and invariably grounded in a shared desire to protect those who may be vulnerable at the end-of-life.

The Panel recognises the significant work undertaken by the Government to design a carefully structured assisted dying framework. We welcome many of the safeguards included in the draft law: mandatory training, repeated assessments of voluntariness, coercion offences, the ability for individuals to pause the process, and clear transparency obligations. Taken together, these provisions demonstrate a genuine commitment to safety and ethical integrity.

Our review also highlights areas where further strengthening is both needed and achievable. Coercion, especially in its subtle and relational forms, requires multidisciplinary expertise that cannot be delivered through medical assessment alone. Decision-making capacity requires enhanced safeguards and clearer guidance, particularly in relation to the proposed waiver. The administration model must prioritise safety and autonomy at every step. The financial and operational planning for such a sensitive service must be both realistic and transparent.

Above all, Islanders must never feel compelled toward an assisted death due to unmet care needs or a lack of accessible information. High-quality end-of-life care and inclusive public awareness are essential pillars of any safe system. The recommendations set out in this report are intended to strengthen the legislation, provide clarity where ambiguity remains, and aim to ensure that the assisted dying framework, if approved by the Assembly, reflects the highest standards of safeguarding, compassion and good governance.

On behalf of the Panel, I extend my sincere thanks to all those who contributed to this review. Their evidence has shaped our findings and will inform the upcoming States debate. We are also extremely grateful for the hard work and expertise of our officers and advisors.

Deputy Louise Doublet

Chair, Assisted Dying Review Panel

Executive Summary

The Assisted Dying Review Panel ("the Panel") undertook a comprehensive examination of the Draft Assisted Dying (Jersey) Law 202– (P.65/2025), assessing its alignment with the principles adopted by the States Assembly through P.18/2024: dignity, informed choice, voluntariness, safeguarding, equality, and ethical integrity. The Panel undertook a rigorous appointment process which led to the appointment of three expert advisers: Professor Suzanne Ost, Professor Nancy Preston and Dr Alexandra Mullock. The expert advisers were requested to consider the legal, academic and medical factors within the draft law.

The Panel's review considered submissions from stakeholders, expert advice and analysis, international evidence, and the Minister for Health and Social Services' responses. It focused particularly on areas identified by the Assembly as central to a safe and ethical assisted dying framework: palliative and end-of-life care, administration of assisted dying, decision-making capacity and the waiver, coercion, training and guidance, public awareness, and funding and implementation.

The Panel acknowledges that the draft law embeds several important safeguards and represents a significant step towards establishing a regulated assisted dying framework. However, the review also identifies areas where key safeguards require strengthening, and where amendments, clearer guidance, and further operational detail are essential to achieve full alignment with the States Assembly's expectations.

Palliative Care and End-of-Life Services

The Panel examined the relationship between assisted dying and end-of-life care, recognising that high-quality care is essential to providing "real choice" and preventing individuals from seeking an assisted death due to unmet needs. The adoption of P.73/2025 establishes a statutory duty to provide end-of-life care before any assisted dying service may commence.

The Panel welcomes the Minister's Second Amendment, which introduces a statutory right to pause the assisted dying process to seek assessment of palliative and end-of-life options. However, the amendment does not guarantee that such assessments are undertaken by a palliative care specialist, leaving uncertainty about the safeguard's effectiveness.

Key Findings:

- End-of-life care provision is fundamental to informed and voluntary choice.
- The statutory duty to provide end-of-life care is welcome but requires clear operationalisation.
- Specialist palliative involvement must be explicitly secured.

Key Recommendations include:

- A clear appeals and dispute-resolution mechanism under P.73/2025.
- Explicit referral pathways between assisted dying and palliative care services.
- Specification that "suitably qualified" professionals include palliative specialists.
- Workforce planning for both end-of-life care and assisted dying.

Processes and Safeguards

Administering Assisted Dying

The draft law permits both self-administration and practitioner administration. Evidence shows that practitioner administration becomes the dominant default mode internationally, raising concerns about autonomy, withdrawal opportunities, and safeguarding during practitioner-led administration.

The Panel concludes that Jersey should adopt a self-administration-first model, with practitioner administration restricted to those physically unable to self-administer and has lodged its Third Amendment to this effect.

Key Findings:

- Practitioner administration carries greater safeguarding risk and becomes the default where offered.
- A self-administration-first model offers stronger protection while maintaining equitable access.
- No minimum experience requirements for Administering Practitioners are set out in the draft law.

Key Recommendations include:

- Minimum experience thresholds for Administering Practitioners.
- Clear criteria for assessing physical incapacity.

Decision-Making Capacity and the Waiver

The draft law introduces a waiver of future capacity, enabling an assisted death to proceed if capacity is lost after Step 6. While intended to protect autonomy, this raises significant ethical and practical concerns.

Stakeholders identified the risks of fluctuating capacity, ambiguous expressions of refusal, and lack of contemporaneous consent. The Panel notes that practitioners' willingness to act under a waiver remains untested and must be established before implementation.

Key Findings:

- Capacity assessments in assisted dying require enhanced safeguards and specialised training.
- The waiver poses significant risks, including potential coercion, misinterpretation of refusal, and lack of contemporaneous decision-making.
- Practitioner willingness and feasibility remain unknown.

Key Recommendations include:

- A further practitioner survey and public consultation specifically on the waiver.
- Guidance on the practical application of the waiver, including fluctuating capacity and withdrawal.
- Training for Administering Practitioners on the ethical and clinical complexities involved.

Coercion

Coercion is acknowledged to be subtle, relational, and often internalised. While the draft law contains strong safeguards, including criminal offences and required checks on voluntariness, the Panel identifies the need for a multidisciplinary approach to assessments.

The Panel proposes its Fourth and Fifth Amendments to strengthen coercion offences and remove third-party appeals, which could otherwise introduce new avenues for undue influence.

Key Findings:

- Coercion can take many forms, requiring specialist expertise to detect.
- The draft law provides substantial safeguards but lacks mandatory multidisciplinary assessment.
- Third-party appeals risk creating coercive dynamics and should be removed.

Key Recommendations include:

- Embedding safeguarding, mental-capacity and social-care specialists in capacity and coercion assessments.
- Clarifying coercion offences and eliminating third-party appeals.

Funding and Implementation Costs

The Budget 2026–29 provides indicative funding for the assisted dying service; however, the Panel finds that cost estimates lack the detailed assumptions necessary for a reliable financial plan.

Evidence demonstrates risks of under-estimation, insufficient contingency provision, and pressure on existing health services.

Key Findings:

- The funding model is indicative only, with critical assumptions missing.
- There is risk of early cost overruns and longer-term financial pressure.
- Stronger transparency and structured financial review are required.

Key Recommendations include:

- A full financial impact assessment prior to implementation.
- Contingency funding and regular financial reviews.
- Clarity on governance costs and draw-down from central reserves.

Training and Guidance

Training and guidance are central to the safe operation of assisted dying. While the draft law embeds statutory training requirements, detailed materials are still under development.

Evidence strongly supports the need for rigorous, multidisciplinary training, covering coercion, capacity assessment, communication with vulnerable groups, and Article 78 compliance.

The Panel has lodged its Seventh Amendment to embed specific coercion-related risk factors into statutory training requirements and extend mandatory safeguarding training beyond clinical practitioners to relevant non-clinical agencies.

Key Findings:

- Training is a core safeguard requiring significant development.
- Full alignment with P.18/2024 depends on enhanced guidance, specialist content and early publication.
- Ongoing monitoring and evaluation are essential.

Key Recommendations include:

- Accredited training covering coercion, mental health, capacity, communication, and ethical practice.

- Co-production of materials with relevant expert bodies.
- A framework for evaluating training effectiveness over time.

Public Awareness

Public awareness is a central safeguard ensuring Islanders can make informed decisions. Stakeholder evidence showed substantial risks of exclusion, especially for disabled Islanders, older adults, and those without digital access.

The Panel welcomes the draft law's neutrality safeguards, but notes that real-world accessibility will be vital.

To enhance public transparency, good governance and oversight, the Panel has lodged its Eighth and Ninth Amendments, requiring the annual assisted dying report to be formally presented to the States Assembly, and a three-year statutory review of the law's implementation requiring disability representation.

Key Findings:

- Public awareness must be proactive, accessible and multi-format.
- Article 78 draws the correct boundary between information and prohibited promotion, but operational support is required.
- Jersey's framework aligns with international practice but needs strong implementation to achieve full effect.

Key Recommendations include:

- An "Accessibility Annex" setting out non-digital, audio, large-print, and Easy Read formats.
- Clear signposting to safeguarding protections in public materials.
- Restricting written materials in GP surgeries unless a professional is present.
- Plain-English annual summaries to support transparency.

Overall Conclusion

The Panel concludes that the Draft Assisted Dying (Jersey) Law largely aligns with the principles of P.18/2024. However, to achieve full and demonstrable alignment, targeted amendments and detailed operational guidance are required, particularly in relation to coercion, decision-making capacity, the waiver, practitioner experience, training, public awareness, and financial preparedness.

The recommendations contained in this report provide a clear pathway to strengthen the framework and seek to ensure that assisted dying, if introduced in Jersey, is delivered safely, ethically, and with the highest possible degree of public confidence.

Key Findings and Recommendations

Key Findings

Palliative Care and End-of-Life Services

KEY FINDING 1: High quality end-of-life care is essential to ensuring real choice and preventing individuals from seeking assisted dying due to unmet care needs.

KEY FINDING 2: The statutory duty to provide end-of-life care represents an important step, but clarity is still needed regarding scope, access, and practical implementation. Detailed guidance and clear interface arrangements between the End-of-Life Care Law and the Assisted Dying Law will be essential to avoid gaps, confusion, or inconsistent provision.

KEY FINDING 3: The Minister for Health and Social Services lodged an amendment to P.65/2025 to clarify that a person may pause the assisted dying process in order to seek assessment from an appropriately qualified health professional on their care and treatment options, including end-of-life and palliative care. This amendment reflects the Minister's commitment that assisted dying should not replace palliative or end-of-life services and aligns with the safeguarding, dignity, and informed-choice principles set out in P.18/2024.

KEY FINDING 4: Whilst the Minister's Second Amendment to the draft law strengthens safeguards to seek assessment for end-of-life care options, it does not require that this assessment be carried out by a clinician with palliative care expertise, leaving uncertainty about whether individuals will receive specialist palliative assessment as standard practice.

Processes and Safeguards: Administering, Decision-making, Coercion, Funding and Implementation

KEY FINDING 5: Practitioner administration carries greater safeguarding risks than self-administration and international data indicates that, despite the availability of self-administration, many individuals prefer or default to practitioner involvement. This trend raises safeguarding concerns related to clinician involvement, reduced opportunities for patient withdrawal, and potential implications for professional roles.

KEY FINDING 6: A self-administration-first model offers stronger safeguards while still enabling equitable access. Expert advisers and stakeholder feedback show that physical incapacity can be reliably assessed in practice, and that Article 10(3) provides a safeguarded route for assisted self-administration with support. This suggests that reserving practitioner administration for those physically unable to self-administer would better balance autonomy, safety, and proportionality, particularly during the introduction of a new and sensitive service.

KEY FINDING 7: Experience requirements for Administering Practitioners remain unclear, creating risks for competence and public confidence. Stakeholders highlighted concerns about newly qualified clinicians undertaking complex assisted dying roles. Despite widespread calls for more experienced practitioners, the draft law currently contains no minimum experience

requirement. This gap risks undermining public trust and practitioner preparedness, especially where opt-out provisions may reduce the pool of available practitioners.

KEY FINDING 8: Public consultation supported choice, but safeguarding imperatives require stronger parameters for implementation. While consultation responses favoured allowing both self-administration and practitioner administration, the evidence indicates that offering an unconstrained choice may dilute safeguards and shift practice toward practitioner-led deaths. Choice must be balanced against the need to minimise coercion risks, reduce practitioner burden and error, and seek to ensure that assisted dying proceeds only where voluntariness is maximally protected.

KEY FINDING 9: Clear guidance and training are required to operationalise safe administration practices. The feasibility of a self-administration-first model, accurate assessment of physical incapacity, and safe practitioner involvement depend on robust, standardised guidance and ongoing training. Without these, variability in practice may compromise safeguards and increase the risk of error, misinterpretation, or inconsistent application of the law.

KEY FINDING 10: The assessment of decision-making capacity in assisted dying requires enhanced, context-specific safeguards. The Capacity and Self-Determination (Jersey) Law 2016 may not be sufficient for decisions involving intentionally ending life. Stakeholders emphasised that end-of-life circumstances, fluctuating cognition, emotional distress, and medication all complicate capacity assessments. The draft law's requirement that capacity must always be actively assessed (rather than presumed) adds an important layer of protection but will require clear training and guidance to be applied consistently.

KEY FINDING 11: Serious concerns exist about the risks and ethical complexity of the waiver of future capacity. The evidence shows consistent concerns that allowing assisted dying to proceed after a person has lost capacity may create risks of acting contrary to the person's final wishes, especially where capacity fluctuates or declines unexpectedly. Stakeholders noted that coercion, undue influence, or changes of mind may go undetected once capacity is lost. Internationally, most assisted dying regimes do not include such waivers, reflecting caution about proceeding without contemporaneous consent.

KEY FINDING 12: Practitioners' willingness and preparedness to act under a waiver remain unknown and may affect feasibility. The survey of healthcare practitioners did not ask whether they would be willing to administer assisted dying under a waiver. Expert advisers highlighted that, unlike Canada where the law permits a waiver of final consent, Jersey has a small clinical workforce, making it essential to understand whether a sufficient proportion of practitioners would undertake this role. Without this information, the operational viability of the waiver remains uncertain.

KEY FINDING 13: Distinguishing refusal from involuntary movement is a recognised safeguarding challenge. The Panel's hearing highlighted practical and ethical risks where an individual loses the ability to communicate clearly or makes ambiguous movements during the procedure. While the draft law requires practitioners to stop at any sign of resistance, stakeholders noted that uncertainty may still arise, with potential consequences for autonomy and safety.

KEY FINDING 14: The waiver supports autonomy for some individuals but increases safeguarding complexity. Expert advisers noted ethical benefits for those who fear imminent loss of capacity, allowing them to avoid premature access to assisted dying. They also identified that the waiver functions similarly in some ways to an advance decision, bringing with it the same

risks recognised internationally: difficulty verifying contemporaneous consent, potential for coercion, and challenges for clinicians administering life ending medication to a now incapacitated person.

KEY FINDING 15: Additional training, clearer guidance, and further consultation are required before the waiver can be safely implemented. The Panel's review found gaps in guidance on how practitioners should apply the waiver, manage fluctuating capacity, identify dissent, and navigate substitute decisions. The Panel identified the need for:

- further practitioner surveys,

- renewed public consultation on support for the waiver,

- specific training for administering practitioners, and

- clear guidance for how to proceed if a person still has capacity on the scheduled day or wishes to pause the process.

KEY FINDING 16: Coercion is multifaceted, often subtle, and requires safeguards that address both external and internal pressures. Evidence consistently demonstrates that coercion rarely presents as overt force. Instead, it may arise through emotional dependence, family dynamics, perceived burden, financial pressures, or relational influence. Safeguards must therefore be designed to detect a wide spectrum of both visible and hidden pressures.

KEY FINDING 17: Certain groups face heightened vulnerability to coercion and abuse, requiring enhanced assessment and specialist expertise. Submissions identified that individuals with mental health conditions, neurodivergence, sensory impairments, diverse personal characteristics or complex social environments may be at particular risk of internalised pressure or undue influence. This reinforces the need for specialist training, careful capacity assessment, and contributions from practitioners with wisdom and expertise in safeguarding, mental health and social care.

KEY FINDING 18: Strong procedural safeguards exist in the draft law, but key gaps remain, particularly around professional expertise, assessment consistency and risk management. While the draft law includes multiple layers of checks (two assessments, voluntariness tests, offences for coercion, prohibitions on promotion of assisted dying, and independent oversight) stakeholders and expert advisers highlighted the need for clearer guidance, specialist training and multidisciplinary involvement to enable these safeguards to operate effectively in practice.

KEY FINDING 19: Effective safeguarding against coercion relies on multidisciplinary assessment, not medical evaluation alone. Across all evidence, a common theme emerged: clinicians cannot realistically be expected to identify all forms of coercion without input from safeguarding professionals, mental capacity specialists and social care practitioners. Multidisciplinary assessment was highlighted as essential for recognising subtle relational pressures, improving consistency, and strengthening public confidence.

KEY FINDING 20: The current financial model for an assisted dying service is indicative only and lacks the detailed assumptions needed for a reliable funding plan. Evidence from expert submissions and the public hearing indicates that the Budget 2026–29 allocations are based on early, high-level estimates rather than a fully developed financial impact assessment. Key cost drivers: governance structures, workforce requirements, inflation, training costs, and digital infrastructure - are not yet clearly established, creating a risk of underestimation.

KEY FINDING 21: There are substantial risks of early cost overruns and longer-term financial pressure. A financial expert raised concerns around structural gaps: no sensitivity testing, no contingency provision, insufficient inflation adjustment, unclear distinction between one-off and recurring costs, and underestimation of specialist training, PMO governance and communications budgets. International evidence (e.g., Western Australia) suggests implementation costs often rise in years two and three, reinforcing the need for a more resilient financial model.

KEY FINDING 22: Stakeholders raised concerns about proportionality and competing pressures on the health budget. Written submissions noted that Health and Community Services faces significant financial pressures across core services. Several concerns were raised about whether a funded assisted dying service (expected to serve a small number of individuals) might divert resources from essential, underfunded areas such as palliative and end-of-life care, mental health, social care, and long-term strategies.

KEY FINDING 23: Funding forecasts are uncertain due to unpredictable demand and limited baseline data. Officers advised that demand, staffing time and case complexity cannot yet be reliably forecasted for a new service. The lack of historical Jersey data means assumptions remain speculative, increasing the need for ongoing review and adjustments.

KEY FINDING 24: Stronger financial modelling, transparency and structured review processes are required to establish a sustainable and accountable service. The evidence demonstrates the need for a full financial impact assessment, planned financial review points, and clear breakdowns of governance and core costs. Without these, the long-term affordability and resilience of the service cannot be guaranteed.

Training and Guidance

KEY FINDING 25: Training is a core safeguard and must be rigorous, detailed and multidisciplinary. The evidence demonstrates that training is not merely an operational requirement but a *primary safeguard* that enables practitioners to detect coercion, assess capacity reliably, navigate ethical complexities and support vulnerable individuals. Without robust training, the protections in the draft law risk being significantly weakened beyond those just involved in the assisted dying service.

KEY FINDING 26: The Draft Assisted Dying (Jersey) Law largely aligns with the principles of P.18/2024; however, important gaps remain in relation to safeguarding, autonomy, equality and operational robustness. Further measures and clarity, including the development of detailed training and guidance are key to full alignment with P.18/2024.

KEY FINDING 27: Coercion detection and capacity assessment require specialist skills beyond standard clinical training. Submissions and expert advice highlighted that coercion can be subtle, internalised or relational, and that certain cohorts face heightened marginalisation and vulnerability. Effective training must therefore include mental health expertise, safeguarding knowledge, and practical tools for identifying complex or hidden forms of undue influence.

KEY FINDING 28: Guidance and training remain under development and must be published early to enable preparedness. Stakeholders consistently raised concerns that guidance is not yet detailed, and the Minister for Health and Social Services confirmed that much of it will be developed during implementation. Early, comprehensive publication is essential to support safe, consistent practice in a small jurisdiction with limited clinical exposure.

KEY FINDING 29: Training must be inclusive, accessible and aligned with wider safeguarding structures. Evidence from disability and safeguarding submissions shows that communication needs vary significantly, and training must reflect the realities of assessing and supporting people with disabilities, sensory impairments, fluctuating capacity and/ or socioeconomic vulnerability. International best practice also emphasises alignment with adult safeguarding frameworks and domestic abuse expertise and economic vulnerability. International best practice also emphasises alignment with adult safeguarding frameworks and domestic abuse expertise.

KEY FINDING 30: Ongoing training, monitoring and evaluation are essential for system integrity and public confidence. Expert advisers and stakeholders stressed the need for continuous updating of training based on international learning, national monitoring outcomes, and emerging risks. Regular evaluation will help to ensure training remains robust, evidence-based and responsive to the evolving practice environment.

Public Awareness

KEY FINDING 31: Public awareness is a core safeguard and must reach all Islanders, including those most marginalised and at risk of exclusion. Stakeholder evidence shows that many Islanders, particularly disabled people, older adults, care-home residents and those without digital access, may otherwise remain unaware of the law's introduction.

KEY FINDING 32: Accessible, inclusive, multi-format, proactive communication is essential to informed choice and equity. Stakeholders and expert advisers emphasised that equitable access requires audio, large print, plain-language materials, Easy Read formats, and alternative routes beyond digital channels. Without these, key groups will be unable to make informed decisions or understand safeguards.

KEY FINDING 33: The draft law's boundary between factual information and prohibited promotion of assisted dying (Article 78) is clear but operationally sensitive. Evidence from the public hearing demonstrated that providers would need support to comply with restrictions on promotional content, especially in clinical settings such as GP practices. This underpinned the Panel's amendment restricting unsupervised written material in GP practices.

KEY FINDING 34: The Panel's analysis shows that, in terms of public awareness, the draft law substantially aligns with the principles set out in P.18/2024 while noting, however, that practical implementation, particularly around accessibility, will be key to fully achieving those principles.

KEY FINDING 35: Jersey's approach to public awareness aligns broadly with international best practice, but successful implementation depends on early guidance, strong accessibility standards and targeted outreach. Expert advisers noted that Jersey's model is consistent with international norms on neutrality, transparency and safeguarding, but warned that real-world delivery (particularly accessible formats, timely publication of guidance, and sensitive engagement with disabled Islanders) will determine whether the framework fully meets best-practice standards.

Recommendations

Palliative Care and End-of-Life Services

RECOMMENDATION 1: The Minister for Health and Social Services should ensure that the statutory consultation on End-of-Life Care [P.73/2025] includes a clear, accessible appeals and dispute-resolution mechanism for families, carers, and professionals. This should address concerns about disagreements relating to eligibility, care planning, or access to services.

RECOMMENDATION 2: The Minister for Health and Social Services should publish detailed guidance on the interface between assessing doctors under the Assisted Dying Law and the statutory duties under the End-of-Life Care Law. This guidance should set out: requirements for informing individuals of all treatment and care options; referral pathways to end-of-life and palliative specialists; and expectations regarding multidisciplinary involvement**.**

RECOMMENDATION 3: The Minister for Health and Social Services should ensure that workforce planning for both end-of-life care and assisted dying is developed and published, recognising the interdependence of the two services and the primary importance of End-of-Life Care. This is necessary to mitigate risks of capacity constraints and seek to ensure the sustainability of services.

RECOMMENDATION 4: The Minister for Health and Social Services should provide clarity on how the States Assembly will be kept informed of progress on implementation of P.73/2025 prior to the commencement of any assisted dying service.

RECOMMENDATION 5: The Minister for Health and Social Services should ensure that statutory guidance will: (a) define "suitably qualified health professional" for the purposes of Articles 4 and 8 to include palliative care specialists where clinically appropriate; and (b) set out time-bound referral and feedback standards so that pauses do not create unnecessary delay or distress.

RECOMMENDATION 6: The Minister for Health and Social Services should ensure that the implementation guidance developed under the Assisted Dying (Jersey) Law includes explicit, cross-referenced referral pathways to palliative and end-of-life care services. This should help to ensure that, when an individual pauses the assisted dying process under Articles 4(3)(b)(iv) and 8(3)(b) to seek further clinical assessment, the referral occurs swiftly, consistently and with clarity across all care settings.

RECOMMENDATION 7: The Minister for Health and Social Services should ensure that the Assisted Dying Service publishes monitoring data demonstrating the use of the pause mechanism, the timeliness of palliative assessments, and any impact on final decisions, in order to support transparency, assurance, and learning during the initial years of implementation. This data should be disaggregated by the characteristics referenced within the coercion-awareness training framework, to enable meaningful analysis of potential risks and patterns associated with vulnerable groups. In addition, consideration should be given to whether States Members, the Minister, and relevant medical professionals should receive this data—in confidence—where appropriate, to allow access to identifying or quasi-identifying statistics that may be necessary for safeguarding purposes. A confidential record of this

information should be maintained so that decision-makers are able to identify any emerging trends that could indicate risk, undue influence, or coercion.

Processes and Safeguards: Administering, Decision-making, Coercion, Funding and Implementation

RECOMMENDATION 8: The Minister for Health and Social Services should ensure that guidance sets out clear, minimum experience requirements for Administering Practitioners, prior to implementation of the draft Law.

RECOMMENDATION 9: The Minister for Health and Social Services should ensure robust criteria for assessing physical incapacity, supported by consistent guidance and regular, ongoing practitioner training.

RECOMMENDATION 10: Due to the proportion of practitioners who would be willing to administer the approved drugs in cases where a waiver is exercised not being identified through the survey conducted in early 2025, there should be a further survey to ascertain this. The aim of this would be to enable feasibility of the implementation of the waiver of future capacity. The Minister for Health and Social Services should undertake this further survey during the implementation stage of the draft law.

RECOMMENDATION 11: The Minister for Health and Social Services should, during the implementation stage of the draft law, ascertain through further public consultation whether there is clear public support for a waiver of future capacity and final consent.

RECOMMENDATION 12: The Minister for Health and Social Services should ensure that the training for administering practitioners covers the practical complexities of the waiver of future capacity and final consent.

RECOMMENDATION 13: The Minister for Health and Social Services should ensure that guidance should include that if a registered assisted dying practitioner is not willing to perform an assisted death where there is a waiver of future capacity, they should make this clear at Step 6 when such a waiver is exercised, so that appropriate planning is possible.

RECOMMENDATION 14: The Minister for Health and Social Services should ensure that guidance for assessing doctors should stipulate what the effect will be on the waiver of the requirement of future capacity if the individual still has capacity on the date set for the occurrence of the assisted death and wishes to pause the assisted dying process. It should also be specified whether, in this event, a new waiver would be required.

RECOMMENDATION 15: The Minister for Health and Social Services should ensure that eligibility assessments for assisted dying are supported by a multidisciplinary team, including safeguarding professionals, mental capacity specialists, and social care practitioners, so that coercion-related risks are examined from multiple professional perspectives. The aim of which being to strengthen the robustness of assessments, improve consistency, and enhance public confidence by ensuring that decisions are informed by a comprehensive understanding of the person's social context, vulnerabilities, and potential sources of undue influence.

RECOMMENDATION 16: The Minister for Health and Social Services should, prior to implementation of the Assisted Dying Service, develop a comprehensive financial impact assessment for the assisted dying service, including detailed assumptions, staffing models, governance structures, and costed operational requirements.

RECOMMENDATION 17: The Minister for Health and Social Services should consider the introduction of contingency funding and scheduled financial reviews, recognising that implementation costs are likely to increase in the early years as the service becomes established.

RECOMMENDATION 18: The Minister for Health and Social Services, in conjunction with the Minister for Treasury and Resources, should ensure transparency in the use of central budget allocations, including a clear breakdown of core governance costs once these are finalised.

Training and Guidance

RECOMMENDATION 19: The Minister for Health and Social Services should ensure a time-bound publication of the statutory general guidance no later than six months before commencement of the law.

RECOMMENDATION 20: The Minister for Health and Social Services should ensure that an accredited training programme includes, but is not limited to, modules on:

a. Mental capacity assessment

b. Ethical reasoning

c. Detection of coercion and undue influence (including subtle, hidden and internalised forms)

d. Domestic abuse indicators and financial coercion

e. Mental health conditions and neurodiversity

f. Communication with disabled and vulnerable individuals

g. Compliance with Article 78

h. Documentation standards and record-keeping

RECOMMENDATION 21: The Minister for Health and Social Services should ensure that training materials are co-produced with experts in disability, mental health, neurodivergence, Diversity, Equity and Inclusion (DEI), domestic abuse and palliative care.

RECOMMENDATION 22: The Minister for Health and Social Services should ensure that evidence from ongoing national and international monitoring be incorporated into training updates; and a formal evaluation framework be established to assess the effectiveness of training and guidance over time.

Public Awareness

RECOMMENDATION 23: The Minister for Health and Social Services should ensure that an "Accessibility Annex" is attached to the guidance, specifying audio, large-print, Easy Read/plain language, and non-digital distribution routes for inclusion and accessibility purposes.

RECOMMENDATION 24: The Minister for Health and Social Services should ensure that in public materials, neutral signposting is included on what to do if someone feels pressured, and a plain explanation of the law's voluntariness/capacity checks.

RECOMMENDATION 25: If the Panel's sixth amendment is adopted, the Minister for Health and Social Services should include in guidance that written materials are provided in GP practices

only in the presence of a health professional, as well as best practice guidance on what this should look like from an operational perspective.

RECOMMENDATION 26: The Minister for Health and Social Services should, alongside the statutory annual report, publish a plain-English summary (reach, accessibility uptake, key learnings) to support transparency and continuous improvement.

RECOMMENDATION 27: The Minister for Health and Social Services should collect robust and appropriate data and evidence during the initial review to demonstrate a clear understanding of the public's awareness of the service. In doing so, the Minister should make every reasonable effort to engage and gather insights from marginalised groups across the island to ensure that all community perspectives are represented.

RECOMMENDATION 28: The Minister for Health and Social Services should incorporate the Panel's sixth amendment concerning written information provided to general practitioners about the assisted dying service as a guiding principle for all settings in which information on assisted dying will be delivered. This principle should be explicitly embedded within the guidance developed to support the implementation and operation of the service, ensuring consistency, clarity, and accessibility across all healthcare and community environments.

1 Introduction

1.1 Background and context

In November 2021, the States Assembly agreed *in principle* that assisted dying should be permitted in Jersey (P.95/2021). However, following an amendment (P.95/2021): Amd to the proposition, the Assembly also required that *detailed final proposals*, including all processes and safeguards, be brought back for debate before law-drafting instructions were prepared. The debate was informed by recommendations made by the Jersey Assisted Dying Citizens' Jury, in which 78% of members supported permitting assisted dying.

In 2022, Islanders took part in the first phase of public engagement. A summary report published in May 2022 highlighted key themes to inform the development of detailed proposals for a second phase of consultation.

Following the June 2022 elections, a 12-week consultation period was held. A second consultation ran from 17th October 2022 to 14th January 2023, resulting in a Consultation Feedback Report published on 28th April 2023. In June/July 2023, the Council of Ministers agreed an updated proposal, informing the external Assisted Dying in Jersey Ethical Review report published on 7th November 2023.

The proposals were debated in the Assembly in May 2024. Given the breadth of the topic and the extensive engagement already undertaken, the Assisted Dying Review Panel focused its scrutiny on assessing the final proposals in relation to written submissions and the existing evidence base. The Panel's Review Report, published on 14th May 2024, made a series of findings and recommendations. The Minister for Health and Social Security's Ministerial Response accepted all four key recommendations, accepted ten others, and partially accepted two.

Following the debate, the Panel continued receiving updates on the progress of law drafting. The draft law was provided to the Panel and other key stakeholders on 9th June 2025. To avoid offering opinion rather than evidence-based scrutiny, the Panel agreed not to provide feedback before the draft law was formally lodged.

The *Draft Assisted Dying (Jersey) Law* [P.65/2025] was lodged on 2nd September 2025 by the Council of Ministers. The proposals outline the legislative provisions *"for the assisted dying of someone who has a terminal illness, who is experiencing (or is expected to experience) unbearable suffering and who chooses to end their life with the help of a medical professional,"* setting out eligibility criteria, processes, oversight mechanisms, regulatory requirements, and essential safeguards. Due to the significance and sensitivity of the topic, thorough scrutiny of the legislation was deemed essential.

1.2 The Panel's Review

On 8th September 2025, the Assisted Dying Review Panel began its review of the draft legislation, engaging with key stakeholders, the public, financial experts, charities, and relevant organisations. The Panel consulted MP Kim Leadbeater, who introduced the Terminally Ill Adults (End of Life) Bill. Recognising the complexity and sensitivity of the legislation, the Panel concluded that specialist expertise was required and appointed three advisers to analyse the medical, academic, and legal dimensions of the draft law.

The Panel focused its review on:

a. Evaluating the proposal's legal, medical, and sustainability implications
b. Identifying any further ethical considerations
c. Assessing alignment with principles of dignity, safeguarding, and freedom of choice
d. Evaluating the adequacy of proposed safeguards for all involved
e. Determining whether the legislation gives effect to the principles adopted by the Assembly in P.18/2024
f. Considering the existing body of evidence, including international models and best practice.

The full Terms of Reference are included at Appendix 1.

The Panel examined the draft legislation against the principles adopted by the Assembly through the adoption of P.18/2024 and undertook comparative analysis with other jurisdictions. International best practice was reviewed to identify potential unintended consequences and propose mitigations. Stakeholder consultation summaries were examined to assess if concerns raised during earlier engagement had been reflected in the drafting. As the review progressed, the Panel expanded its focus to include issues such as coercion, training and guidance, and palliative care. It considered the *End-of-Life Care* proposition [P.73/2025], presenting Comments to the Assembly and noting divergent views among Panel Members.

1.3 Methodology

This section describes the approach used to review the draft legislation, assess its alignment with established principles, and evaluate its suitability for a small jurisdiction like Jersey. The review methodology combined qualitative legislative analysis, comparative benchmarking against international best practice, and the incorporation of stakeholder feedback to inform rigorous scrutiny.

The Panel reviewed the draft legislation in detail, comparing it with earlier versions to identify key changes and assessing these against the principles adopted by the States Assembly and relevant international frameworks. Supporting documentation, including the addendum, ethical review, and other materials, was referenced throughout.

To enable stakeholder engagement, the Panel contacted 15 key stakeholders who had received the draft legislation before publication to determine whether previously raised concerns had been addressed. Following structured interviews, three expert advisers were appointed to provide specialist legal, ethical, and academic analysis. The advisers met with the Panel fortnightly to discuss emerging issues.

Public engagement included a call for evidence via social media, enabling Islanders to share views. 20 targeted letters were also sent to financial experts for submissions on relevant aspects of the draft law. The Panel assessed public awareness of both the debate and potential implementation of assisted dying by conducting a social media poll, which received 128 votes 94% who were aware and 6% who were not. In addition, the Panel wrote to 17 residential homes, nursing homes, and charities to enable inclusion of those not reached through digital channels. This multi-layered methodology aimed to support an inclusive, evidence-based, and internationally aligned review process, bringing together legislative scrutiny, expert input, stakeholder perspectives, and public consultation to form a thorough and balanced assessment of the draft legislation.

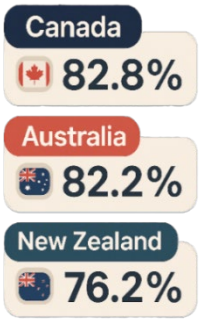
2 Palliative Care and End-of-Life Services

2.1 Background

In Jersey, people who are at their end-of-life are currently offered end-of-life care. This can be provided in their own home, in a residential home, in the Jersey Hospice, or in the hospital. This decision is dependent upon an individual's circumstances and their preferences.

In the 2023, the States Assembly agreed £3 million additional investment per year in palliative and end-of-life care services via the Government Plan. This additional investment has supported the End-of-life Care Partnership ("EOL Partnership") to develop and oversee delivery of a Palliative and End-of-life Care Strategy for Adults in Jersey ("the Strategy").

In countries where assisted dying is legal, such as Canada, Australia and New Zealand, the majority of people requesting an assisted death also receive end-of-life care. The data suggests that 82.8% of individuals in Canada[1], 82.2% in Australia, and 76.2% in New Zealand accessed end-of-life care alongside their assisted dying request. These figures indicate that in countries where assisted dying is permitted, assisted dying services complement, rather than replace, palliative care services.



2.2 End-of-Life Care Proposition [P.73/2025]

The adoption of the End-of-Life Care Proposition [P.73/2025] on 20th January 2026 requires that a statutory duty be placed on the Minister for Health and Social Services to bring forward the necessary future legislation to ensure the provision of end-of-life care services in Jersey before any assisted dying framework is implemented.

The future End-of-Life Care Law will be required to include provisions that:

- Place a duty on the Minister for Health and Social Services to arrange, or ensure arrangements are in place for identifying individuals who are approaching the end of their life and assessing the care needs of those individuals.
- Require the Minister to provide, or arrange for the provision of, appropriate care for people nearing the end-of-life, whether they are living at home or in a care setting such as a hospital, hospice, or care home, regardless of whether the facility is operated by the Minister.
- Define the types of care to be delivered or allow the Minister to set out those types by Order.
- Establish the standards of care to be met or empower the Minister to determine those standards by Order.
- Specify who is eligible to receive services or enable the Minister to do so by Order. This may include:
    - Individuals approaching the end-of-life;

[1] Second Annual Report on Medical Assistance in Dying in Canada 2020 - Canada.ca

    - Their family members and friends;
    - Health and care professionals involved in their care.
- Specify other matters which appear to the Assembly to be necessary to the provision of care to people at the end of their life
- Specify whom the Minister must or may consult before making any Orders under the law.

A future draft End-of-Life Care Law would also allow the Minister to set out, by Order, the types and standards of care to be provided. This flexibility acknowledges that both may need to evolve over time in response to medical advances and changes in professional practice.

The World Health Organization describes palliative care as *an approach that improves the quality of life of patients and their families facing life-threatening illness, through the prevention and relief of suffering by means of early identification, assessment, and treatment of pain and other issues - physical, psychosocial, and spiritual*[2]. Key features of end-of-life care typically include:

- Pain and symptom management
- Emotional, psychological, and spiritual support
- Support for families and carers
- Coordination of care across settings (home, hospital, hospice)
- Respect for patient preferences and dignity.

The proposition focuses specifically on end-of-life care, defined as palliative care provided during the final 12 months of life, rather than on broader palliative care services that may be delivered earlier in the course of a life-limiting illness. This targeted approach reflects the decision made by the States Assembly during the debate on P.18/2024, where it was agreed that assisted dying should only be available to individuals who are at the end-of-life.

As a result, a proposed End-of-Life Care Law will be designed to align with that policy position by ensuring that high-quality care and support are available to those nearing the end-of-life, including individuals who may be eligible to request an assisted death. It does not extend to those living with incurable physical medical conditions who are experiencing significant suffering but are not considered to be approaching the end-of-life.

2.2.1 Themes from the Public Hearing with the Minister for Health and Social Services

End-of-Life Care vs Broader Palliative Care

The Panel questioned the Minister during a public hearing[3] regarding the decision to impose a statutory duty solely in relation to end-of-life care rather than palliative care more broadly. The Panel was informed that this approach reflected the Assembly's earlier decision under

[2] *World Health Organization*, "Palliative Care," accessed February 9, 2026, https://www.who.int/health-topics/palliative-care#:~:text=Palliative%20care%20is%20a%20crucial,capacity%20and%20to%20disseminate%20information

[3] Transcript – Public Review Hearing with the Minister for Health and Social Services – 19 November 2025

P.18/2024 to restrict assisted dying to individuals who were terminally ill and at the end-of-life, and to exclude those experiencing unbearable suffering who were not terminally ill.

It also heard that palliative care for non-end-of-life patients already formed part of general health service provision, and that placing a legal duty on the Minister for one specific service but not others, such as cancer treatment, was considered inequitable.

The Panel further established that, should the Assisted Dying Law in future be extended to include individuals experiencing unbearable suffering outside end-of-life, a parallel extension to the statutory duty would likely be required.

Access to End-of-Life Care in Preferred Care Settings

The Panel sought assurance that the proposition would support equitable access to high-quality end-of-life services across all settings, including home, residential care, the hospice and the hospital. It was informed that the proposed duty would require the Minister to ensure that individuals believed to be in their last 12 months of life had their needs assessed and met, with the detailed arrangements to be developed through consultation. The Panel noted that existing work under the End-of-Life Care Partnership and Strategy already placed significant emphasis on enabling people to receive care, and often to die, in their preferred setting, most commonly at home.

Monitoring and Review of End-of-Life Care

The Panel examined how delivery of end-of-life care would be monitored over time. It was told that quarterly reporting mechanisms were already in place, alongside regular meetings with service providers and a wide partnership group. These structures were presented as providing a robust, formalised mechanism for monitoring performance and ensuring ongoing oversight of the End-of-Life Care Strategy.

P.73/2025 - Appeals Process

In follow-up correspondence, the Panel sought clarity on whether there would be routes for appeals or challenges by relatives in cases where disagreements might arise regarding eligibility, care planning or access to services. The Panel was informed that these issues had not yet been fully considered but would form part of the consultation process following the adoption of P.73/2025.

2.2.2 Panel's Observations on the Statutory Duty in the Context of Assisted Dying

The Panel explored how the new statutory duty would interact with the Assisted Dying legislation. It received assurances that both pieces of work were underpinned by the principle of ensuring "*real choice*," whereby no individual should feel compelled to seek an assisted death due to inadequate access to care. The Minister highlighted that assessing doctors would have a clear duty to inform individuals of their care and treatment options, including end-of-life and palliative options. The Panel also noted the importance of the work undertaken by the End-of-Life Care Partnership and the Assembly's decision to invest an additional £3 million in end-of-life care.

The Panel examined the proposition in detail, noting that the level of detail and commitment to end-of-life care had been comprehensive. The Panel shared the proposition with its expert

advisers, as part of their work on the Assisted Dying legislation, and no significant concerns were raised at that stage.

The Panel was ultimately unable to reach a collective position on P.73/2025, largely due to questions about whether the chosen legislative structure was necessary or optimal. Some Members expressed reservations that the policy objectives might be more effectively achieved through amendments to the existing Assisted Dying legislation, which could offer a more streamlined and less administratively complex mechanism. The Panel presented Comments, published on 16th January 2026 to assist Members ahead of the debate which outlined the Panel's observations and concluding that the proposition represented an important step toward establishing a statutory framework for the provision of end-of-life care in Jersey. By placing defined duties on the Minister for Health and Social Services, it aimed to ensure that individuals approaching the end-of-life receive appropriate, high-quality care.

Key Findings

KEY FINDING 1: High quality end-of-life care is essential to ensuring real choice and preventing individuals from seeking assisted dying due to unmet care needs.

KEY FINDING 2: The statutory duty to provide end-of-life care represents an important step, but clarity is still needed regarding scope, access, and practical implementation. Detailed guidance and clear interface arrangements between the End-of-Life Care Law and the Assisted Dying Law will be essential to avoid gaps, confusion, or inconsistent provision.

Recommendations

RECOMMENDATION 1: The Minister for Health and Social Services should ensure that the statutory consultation on End-of-Life Care [P.73/2025] includes a clear, accessible appeals and dispute-resolution mechanism for families, carers, and professionals. This should address concerns about disagreements relating to eligibility, care planning, or access to services.

RECOMMENDATION 2: The Minister for Health and Social Services should publish detailed guidance on the interface between assessing doctors under the Assisted Dying Law and the statutory duties under the End-of-Life Care Law. This guidance should set out: requirements for informing individuals of all treatment and care options; referral pathways to end-of-life and palliative specialists; and expectations regarding multidisciplinary involvement.

RECOMMENDATION 3: The Minister for Health and Social Services should ensure that workforce planning for both end-of-life care and assisted dying is developed and published, recognising the interdependence of the two services and the primary importance of End-of-Life Care. This is necessary to mitigate risks of capacity constraints and seek to ensure the sustainability of services.

RECOMMENDATION 4: The Minister for Health and Social Services should provide clarity on how the States Assembly will be kept informed of progress on implementation of P.73/2025 prior to the commencement of any assisted dying service.

2.3 Embedding Palliative Care Safeguards in the Assisted Dying Law

If the Draft Assisted Dying Law is adopted, it will give some people with a terminal illness the option to choose how and when they die, giving them more control at the end-of-life. The report to the Proposition states that '*all people approaching end-of-life need to be able to access the end-of-life care they need to maximise quality of life and minimise any suffering or distress'*. This will include people who have requested an assisted death; therefore, end-of-life care will continue to be provided to people who have requested an assisted death.

During the Panel's Review into Assisted Dying in 2024, two recommendations were made and accepted by the Minister regarding palliative care:

Key Recommendation 1: *The Minister for Health and Social Services should publish a plan to evidence the quality and availability of palliative and end-of-life care in Jersey, by no later than two months before the assisted dying legislation is scheduled for debate by the States Assembly.*

The Panel notes that the Addendum to the draft law includes a comprehensive report providing this evidence, including service assessments, benchmarking against NHS and NICE standards, and updates on improvements such as the establishment of the Living Well Team and 24/7 specialist advice

Recommendation 2: *The Minister for Health and Social Services should confirm the timeline for the development of a Palliative and End-of-Life Care Strategy beyond 2026, by no later than two months before the assisted dying legislation is scheduled for debate by the States Assembly.*

The Addendum to the draft law states that an updated Strategy for 2027–2031 will be published at the end of 2026, informed by a service review scheduled for Q2 2026.

2.3.1 Jersey Care Commission's Concerns and the Minister's Second Amendment

During the Panel's call for evidence, the Jersey Care Commission (JCC)[4] submitted evidence emphasising the importance of formally involving palliative care expertise within the assisted dying pathway and making explicit a person's right to access palliative and end-of-life care at any point in the process. The Panel sought Ministerial assurance that these points would be reflected on the face of the Law or in binding guidance.

On 6th February 2026, the Minister for Health and Social Services lodged the Second Amendment to the Draft Assisted Dying (Jersey) Law (P.65/2025). Among other drafting changes, the amendment clarifies a person's ability to pause the assisted dying process to seek assessment by an appropriately qualified health professional for care and treatment options, including end-of-life and palliative options, and requires this right to be communicated at key steps and recorded appropriately.

Key amendments relevant to the JCC submission include:

- **Duty to inform (Article 4 and Article 8):**

  The amendment inserts wording to clarify that an individual is told that, at any time before the approved drugs are administered, they may withdraw their request or pause

[4] Written Submission, Jersey Care Commission, 04 November 2025

the assisted dying process and ask for examination by a suitably qualified health professional to determine care and treatment options, including end-of-life and palliative options.

- **Care plan requirements (Article 8(4)):**

  The amendment restructures the care plan requirements so that an individual's preferences are explicitly recorded: when and where the assisted death would occur, who would administer the approved drugs (self-administration or practitioner), and how the drugs would be administered (e.g., swallowing or injection). While primarily about preferences, this structured plan sits alongside the new explicit right to pause and seek palliative options, strengthening visibility of alternatives within the individual's documented pathway.

The Government of Jersey's website[5] states that *"assisted dying does not replace palliative and end-of-life care"* and that people should be provided the care and treatment needed to maximise quality of life and minimise suffering[6]. The Minister's amendment gives this policy position operational force inside the statutory pathway by making the option to pause and seek palliative assessment explicit.

2.3.2 Alignment with P.18/2024 Principles

The Panel has considered how the proposals outlined in the previous section align with the principles agreed through the adoption of P.18/2024, as follows:

Safeguarding and dignity: By framing a clear right to pause and seek palliative assessment, the amendment enhances safeguards against any perception of default progression toward an assisted death where treatable symptoms or alternative supportive options might instead be appropriate, thereby supporting dignity and informed decision-making.

Freedom of choice and "real choice": Embedding the pause for palliative assessment directly addresses the risk that a person proceeds because they are unaware of available care. It therefore strengthens the principle of freedom of choice grounded in full information and access to services.

2.3.3 Panel's Observations

The Panel welcomes the insertion of a clear, statutory right to pause the assisted dying process to obtain assessment by a suitably qualified health professional regarding care and treatment options, including end-of-life and palliative care. This responds to the JCC's submission and is consistent with the Assembly's principle of "real choice" established under P.18/2024 and carried forward in P.65/2025.

The Panel notes that the Draft Assisted Dying Law defines "health professional" broadly, encompassing doctors, nurses, pharmacists, technicians, dentists, allied health professionals and any registrable occupation under the Health Care (Registration) (Jersey) Law 1995. While this definition includes palliative care physicians and specialist nurses by virtue of their

[6] Government of Jersey, 'Assisted Dying' accessed February 9th 2026

professional registration, it does not distinguish them from other health professionals nor guarantee their involvement in the assessment process.

The Minister's Second Amendment introduces a statutory right for an individual to pause the assisted dying process and request examination by a "suitably qualified health professional" to determine their treatment and care options, including end-of-life and palliative options. However, the amendment does not specify that this assessment must be undertaken by a clinician with palliative care expertise. The Panel considers that, while the amendment reflects the spirit of the Jersey Care Commission's submission, it does not provide full assurance that individuals will receive specialist palliative assessment as standard practice.

Accordingly, the Panel considers that implementation guidance and service protocols must explicitly require the involvement of appropriately qualified palliative care specialists in relevant assessments. This is necessary to help ensure that individuals are fully informed of realistic care options, safeguard the principle of "real choice", and promote consistency across the assisted dying pathway.

The Panel also notes the strengthened care-planning transparency (Article 8(4)) and considers that implementation guidance should cross-reference the referral pathways to palliative and end-of-life services so that the "pause" mechanism operates swiftly and consistently across settings.

The Panel makes the following key findings and recommendations.

Key Findings

KEY FINDING 3: The Minister for Health and Social Services lodged an amendment to P.65/2025 to clarify that a person may pause the assisted dying process in order to seek assessment from an appropriately qualified health professional on their care and treatment options, including end-of-life and palliative care. This amendment reflects the Minister's commitment that assisted dying should not replace palliative or end-of-life services and aligns with the safeguarding, dignity, and informed choice principles set out in P.18/2024.

KEY FINDING 4: Whilst the Minister's Second Amendment to the draft law strengthens safeguards to seek assessment for end-of-life care options, it does not require that this assessment be carried out by a clinician with palliative care expertise, leaving uncertainty about whether individuals will receive specialist palliative assessment as standard practice.

Recommendations

RECOMMENDATION 5: The Minister for Health and Social Services should ensure that statutory guidance will: (a) define "suitably qualified health professional" for the purposes of Articles 4 and 8 to include palliative care specialists where clinically appropriate; and (b) set out time-bound referral and feedback standards so that pauses do not create unnecessary delay or distress.

RECOMMENDATION 6: The Minister for Health and Social Services should ensure that the implementation guidance developed under the Assisted Dying (Jersey) Law includes explicit, cross-referenced referral pathways to palliative and end-of-life care services. This should help to ensure that, when an individual pauses the assisted dying process under Articles 4(3)(b)(iv) and 8(3)(b) to seek further clinical assessment, the referral occurs swiftly, consistently and with clarity across all care settings.

RECOMMENDATION 7: The Minister for Health and Social Services should ensure that the Assisted Dying Service publishes monitoring data demonstrating the use of the pause mechanism, the timeliness of palliative assessments, and any impact on final decisions, in order to support transparency, assurance, and learning during the initial years of implementation. This data should be disaggregated by the characteristics referenced within the coercion-awareness training framework, to enable meaningful analysis of potential risks and patterns associated with vulnerable groups. In addition, consideration should be given to whether States Members, the Minister, and relevant medical professionals should receive this data—in confidence—where appropriate, to allow access to identifying or quasi-identifying statistics that may be necessary for safeguarding purposes. A confidential record of this information should be maintained so that decision-makers are able to identify any emerging trends that could indicate risk, undue influence, or coercion.

3 Processes and Safeguards

3.1 Background

In reviewing the proposed Assisted Dying legislation, the Panel undertook a comprehensive assessment of the processes and safeguards set out within the draft provisions. This examination was conducted alongside consideration of the published ethical review, feedback from the Panel's expert advisers, and the submissions received during the consultation process.

Safeguards are a critical component of any Assisted Dying framework. They exist to aim to ensure that the process is carried out with the highest standards of care, transparency, and accountability, protecting both individuals seeking an assisted death and those involved in its delivery. Effective safeguards help to uphold autonomy while preventing coercion, error, or misuse, and they provide reassurance that decisions are made in a manner that is ethically sound and legally robust.

The Panel's evaluation therefore focused not only on whether the proposed processes are clear and workable, but also on whether the safeguards are sufficient to maintain public trust and protect vulnerable individuals. This section sets out the Panel's findings in relation to these considerations.

3.2 Safeguards: Administering

This section outlines the approach taken in the draft law regarding how assisted dying may be administered, as this is a key element of the proposed framework.

The draft law provides for two modes of administration:

- **Self-administration**, where the individual takes the approved medication themselves; and
- **Practitioner-administration**, where the Administering Practitioner physically administers the medication to the individual.[7]

It is noted that the decision to include both options was intended to aim to ensure that assisted dying remains accessible to individuals who may be unable to self-administer. This approach differs from the Terminally Ill Adults (End of Life) Bill, which permits only self-administration. The Ethical Review Panel noted that there are reasonable arguments both for and against each method.[8] The Ethical Review further noted that should the States Assembly consider these arguments to be balanced, it might have been appropriate to permit both modes in legislation, thereby allowing patients to choose. Such an approach would be in alignment with the central objective of respecting patient autonomy.

However, the Ethical Review considered that the Assembly might also have preferred to prioritise self-administration and limit practitioner-administration to exceptional circumstances, if further consideration was given to the following factors. Practitioner-administration was associated with greater concerns, including reported increases in its use over time in jurisdictions where it was permitted, potential implications for the role of healthcare professionals, and comparatively low rates of patient withdrawal once practitioners were directly involved. These factors suggested that self-administration could have been the more prudent primary approach. Nevertheless, reserving practitioner-administration for individuals physically unable to self-administer would have addressed concerns regarding equitable access.

Finally, it was noted that if self-administration were to be permitted, international experience indicated the need for careful evaluation of the various drugs and methods used elsewhere to ensure that the safest and most effective approach was adopted.

Under the proposed legislation, the Administering Practitioner is defined as the doctor or registered nurse who supports the individual in developing their assisted dying care plan, assists with administration, and remains present during the individual's death.[9] The draft law allows the Administering Practitioner to decline to administer the medication directly. This reflects that some practitioners only support assisted dying where the individual takes the final step themselves, consistent with the principle that the individual exercises choice and autonomy.

The draft law also provides that both the Administering Practitioner and the administration witness may opt out of practitioner administration while still enabling the individual to proceed through self-administration if they choose.

3.2.1 Concerns Raised in the Panel's Previous Review

During the Panel's previous review, it found that many respondents with a healthcare background who participated in the Government's Phase 2 Consultation on Assisted Dying believed the role of the Administering Practitioner should not be undertaken by newly qualified doctors. Some respondents suggested a minimum of five years' experience, while others referred to the Australian model requiring consultant level or ten years post-qualification. The

[7] Assisted Dying in Jersey Ethical Review, November 2023, p.20
[8] Assisted Dying in Jersey Ethical Review, November 2023, p.16
[9] Draft Assisted Dying (Jersey) Law 202- (2 September 2025), p.10.

Nursing and Midwifery Council also questioned limiting certain assessment roles to doctors only, suggesting nurses could be suitable.

In response, the Panel requested clarification on the level of experience required under the final proposals. The Minister advised that doctors and registered nurses would need to have at least 12 months post-registration experience with the General Medical Council or Nursing and Midwifery Council.[10] However, the rationale for this threshold was not provided, despite consultation feedback recommending significantly higher experience requirements.

The Panel therefore requested that the rationale for the proposed experience requirement be clearly explained and considered in light of stakeholder concerns. The Report further explains this on page 27.

The Panel notes that during its current review it considered the above discussions and observed there is no reference in the draft law to the level of experience required for the Administering Practitioner role. The absence of this detail may have implications for implementation and public confidence, as clarity on professional experience requirements is important to promote competence, safeguard patients, and maintain trust in the assisted dying process.

3.2.2 Themes from the Public Hearing with the Minister for Health and Social Services

During the Panel's Public Hearing[11] with the Minister for Health and Social Services, the Minister explained that the option of adopting the Australian state of Victoria's more restrictive approach (where practitioner administration is only permitted when a patient is physically unable to self-administer) had been considered but ultimately rejected. Healthcare professionals had raised concerns about having to define "physically unable," and the Minister confirmed that this concern contributed to the decision not to follow the Victorian model.

The Panel noted, however, that the expert advisers reported no evidence of system-level difficulty in Victoria in determining whether a patient was unable to take or digest the approved drugs.

The Minister further confirmed at the hearing that restricting practitioner administration solely to cases of physical incapacity would not align with the outcomes of Jersey's public consultation, which indicated strong public support for providing individuals with a genuine choice between modes of assisted dying. The Citizens' Jury had similarly emphasised autonomy and choice as key reasons for offering both practitioner administration and self-administration.

The Panel also reflected on Article 10(3) of Jersey's draft law, which allows a family member or friend to assist an individual with self-administration. During the hearing, discussion highlighted that if the law were amended in line with the Victorian model, this provision would create a pathway whereby a person could self-administer with assistance where physically able, or access practitioner administration if not. This appeared consistent with several of the considerations the Citizens' Jury had raised in support of offering both methods.

3.2.3 Expert Advisers' Findings on Administration

[10] Letter from the Minister for Health and Social Services to the Chair of the Assisted Dying Review Panel – 10 April 2024

[11] Transcript – Public Hearing with the Minister for Health and Social Services – 19 November 2025

The Expert Advisers' Report[12] provided detailed comparative evidence on modes of administration in jurisdictions where both practitioner-administered and self-administered assisted dying are permitted. Across these jurisdictions, the advisers reported that the majority of individuals choose practitioner administration, identifying three principal reasons for this pattern:

1. Greater reliability of practitioner-administered methods
2. Preference for a medically supervised death
3. Physical incapacity preventing some individuals from self-administering the medication.

Evidence from Canada demonstrated that practitioner administration had been overwhelmingly preferred. The advisers noted that in 2023, there were fewer than five cases of self-administration nationwide, despite self-administration being legally available across most provinces and territories since 2016. Similar patterns were observed in Australian states, where practitioner administration is also authorised. Similar patterns were observed in Australian states, where practitioner administration is also authorised.

The Panel also reviewed evidence from Victoria, Australia, where practitioner administration is permitted only when a patient is physically unable to self-administer. According to the Victorian Review Board's 2024–25 Annual Report, 142 practitioner-administered permits had been issued compared with 492 self-administration permits. The advisers cautioned that the lower rate of practitioner administration in Victoria likely reflects the legal restriction, rather than a lack of patient preference for clinician involvement.

The advisers further considered the implications of Article 10(3) in Jersey's draft law. They indicated that, if Jersey were to adopt a model similar to Victoria's, this provision could theoretically allow an individual to self-administer with assistance if physically able, or to access practitioner administration when not. However, the advisers also warned that restricting practitioner administration only to cases of physical incapacity would represent a significant limitation on patient autonomy, particularly in light of the strong international evidence showing the majority preference for practitioner administration. Autonomy was also identified by the Citizens' Jury as a key justification for making practitioner administration available.

The advisers did not provide a view on whether a self-administration model should be adopted, nor did they identify any model as preferable, as such determinations fall outside the scope of their remit. Their contribution was limited to the provision of factual information, including comparative insights from other jurisdictions, without expressing a position on any specific approach.

3.2.4 The Panel's Third Amendment - Administration

Having weighed the full body of evidence and stakeholder feedback, the Panel concluded that a self-administration-first model, with practitioner-administration restricted to cases of physical incapacity, would have delivered the strongest safeguards while maintaining equitable access.

[12] Expert Advisers report - Review of the Draft Assisted Dying Legislation

This position was reinforced by:

(i) consistent international patterns showing that practitioner-administration predominates where both modes are available, highlighting the need to balance patient preference with safeguarding concerns; -administration predominates where both modes are

(ii) evidence from other jurisdictions demonstrating that determining whether an individual is physically unable to self-administer can be assessed reliably in practice; and

(iii) the effect of Article 10(3), which provided a safeguarded pathway for assisted self-administration with the support of a family member or friend, thereby preserving autonomy wherever possible.

The Panel further considered that closer alignment of Jersey's legal provisions with those in England, Scotland, the Isle of Man and other British Isles jurisdictions would offer an additional advantage for professionals who practise across these jurisdictions—including those who also work in Jersey—by providing consistency in legal and clinical frameworks.

The Panel further noted the importance of establishing clear and robust experience requirements for the Administering Practitioner role to maintain professional competence and public confidence, particularly given the opt-out provisions designed to protect practitioners' conscientious positions. While recognising that public consultation supported offering a genuine choice of administration mode, the Panel determined that safeguarding imperatives, particularly the need to reduce risks of coercion, distress, practitioner burden and error, should take precedence. Accordingly, following these conclusions, the Panel resolved to lodge an amendment[13] to the draft law to reflect a model in which self-administration is the primary route, with practitioner-administration available only where an individual is physically unable to self-administer.

3.2.5 Panel's Observations

Having considered the evidence, the Panel considers that self-administration should remain the primary mode of assisted dying, with practitioner administration reserved only for those who are physically unable to self-administer. The evidence shows that practitioner administration becomes the dominant method in jurisdictions where both options are available, and that assessments of physical incapacity can be made reliably. This approach would better balance autonomy with safeguarding concerns, particularly at the introduction of a new and sensitive service. Self-administration should remain the primary mode of assisted dying, with practitioner administration reserved for those who are physically unable to self-administer. The evidence shows that practitioner administration becomes the dominant method in jurisdictions where both options are available, and that assessments of physical incapacity can be made reliably. This approach would better balance autonomy with safeguarding concerns, particularly at the introduction of a new and sensitive service.

The Panel also remains concerned by the absence of defined experience requirements for the Administering Practitioner role. Given the complexity and ethical sensitivity of the task, clear professional criteria are needed to maintain public confidence and promote competence.

The Panel makes the following key findings and recommendations.

[13] Draft Assisted Dying (Jersey) Law 202- (P.65/2025): third amendment

Key Findings

KEY FINDING 5: Practitioner administration carries greater safeguarding risks than self-administration and international data indicates that, despite the availability of self-administration, many individuals prefer or default to practitioner involvement. This trend raises safeguarding concerns related to clinician involvement, reduced opportunities for patient withdrawal, and potential implications for professional roles.

KEY FINDING 6: A self-administration-first model offers stronger safeguards while still enabling equitable access. Expert advisers and stakeholder feedback show that physical incapacity can be reliably assessed in practice, and that Article 10(3) provides a safeguarded route for assisted self-administration with support. This suggests that reserving practitioner administration for those physically unable to self-administer would better balance autonomy, safety, and proportionality, particularly during the introduction of a new and sensitive service.

KEY FINDING 7: Experience requirements for Administering Practitioners remain unclear, creating risks for competence and public confidence. Stakeholders highlighted concerns about newly qualified clinicians undertaking complex assisted dying roles. Despite widespread calls for more experienced practitioners, the draft law currently contains no minimum experience requirement. This gap risks undermining public trust and practitioner preparedness, especially where opt-out provisions may reduce the pool of available practitioners.

KEY FINDING 8: Public consultation supported choice, but safeguarding imperatives require stronger parameters for implementation. While consultation responses favoured allowing both self-administration and practitioner administration, the evidence indicates that offering an unconstrained choice may dilute safeguards and shift practice toward practitioner-led deaths. Choice must be balanced against the need to minimise coercion risks, reduce practitioner burden and error, and to seek to ensure that assisted dying proceeds only where voluntariness is maximally protected.

KEY FINDING 9: Clear guidance and training are required to operationalise safe administration practices. The feasibility of a self-administration-first model, accurate assessment of physical incapacity, and safe practitioner involvement depend on robust, standardised guidance and ongoing training. Without these, variability in practice may compromise safeguards and increase the risk of error, misinterpretation, or inconsistent application of the law.

Recommendations

RECOMMENDATION 8: The Minister for Health and Social Services should ensure that guidance sets out clear, minimum experience requirements for Administering Practitioners, prior to implementation of the draft law.

RECOMMENDATION 9: The Minister for Health and Social Services should establish robust criteria for assessing physical incapacity, supported by consistent guidance and regular, ongoing practitioner training.

3.3 Safeguards: Decision-making capacity, the Waiver of Final Confirmation of Consent

This section sets out the provisions in the draft law concerning the assessment of decision-making capacity, examines the proposed waiver mechanism, and summarises the evidence considered during the Panel's review.

The draft law includes a provision allowing an individual, at Step 6 of the assisted dying process, to waive the requirement to retain decision-making capacity at later stages. This waiver applies where an individual lost capacity after their request has been approved (Step 5) but before the final confirmation stage (Step 7). Its purpose is to seek to ensure that an approved request could still proceed if capacity deteriorated during the intervening period and decision-making capacity at later stages. This waiver applied where an individual lost capacity after their request had been approved (Step 5) but before the final confirmation stage (Step 7).

The draft law also clarifies how the waiver would operate. Individuals choosing to waive the future capacity requirement are required to make their final request at Step 6 rather than Step 7. The Administering Practitioner could only confirm the waiver if they are satisfied that the individual has capacity at Step 6 and that the request was voluntary. The waiver applies both to the requirement for capacity at Step 7 and to the capacity required to move from Step 6 to Step 7, addressing an omission in earlier proposals.

Additional safeguards are included. The draft law provides that an assisted death could not proceed if the individual demonstrated refusal or resistance through words, sounds or gestures, even where a waiver had been made.

3.3.1 Concerns raised in Written Submissions

During its review, the Panel received a number of submissions regarding capacity and the waiver. Dr Stewart-Jones on behalf of the Jersey Dying Well Group[14] raised a number of concerns about the use of Jersey's Capacity and Self-Determination (Jersey) Law 2016 for assessing capacity in relation to assisted dying. He indicates that, because the Jersey law is closely modelled on the UK Mental Capacity Act 2005 (MCA), the limitations identified in the UK regarding the MCA's suitability for assisted dying would also apply in Jersey.

The extract provided from the article *"Why physician-assisted suicide has no place in the NHS"* by S Hollins, I Finlay and R Zinchenko sets out the following key points:

1. **The MCA was not designed for life-ending decisions**

   The submission states that although the MCA presumes capacity and provides a framework for assessing when a person lacks capacity, it was not intended to be used to confirm capacity for decisions involving intentionally ending one's life. The authors argue that such decisions carry unique ethical considerations that the MCA does not address.

2. **Concerns about reversing the presumption of capacity**

[14] Written Submission, Dr John Stewart-Jones, 07 November 2025

The submission suggests that requiring a formal capacity assessment for assisted dying effectively treats the wish to die as inherently suspect or pathological, which the authors argue conflicts with how the MCA is normally applied.

3. **Lack of evidence the MCA is suitable for assisted dying**

   According to the submission, no research has tested whether the MCA is appropriate or reliable for assessing capacity in the assisted dying context, especially given the emotional and existential pressures someone may experience at the end-of-life.

4. **Concerns about asking psychiatrists to assess capacity for assisted dying**

   The submission highlights a perceived contradiction: psychiatrists currently view suicidal thoughts as a sign of mental disorder prompting medical intervention. Asking the same clinicians to validate similar thoughts for the purpose of assisted dying could, in the view of the authors, put them in a conflicting professional position.

5. **Reference to the Royal College of Psychiatrists' position**

   The submission states that the Royal College of Psychiatrists has expressed concerns in England and Wales and in Jersey about using current capacity legislation to support assisted dying, including issues around assessing capacity safely and consistently.

6. **Objection to the draft law's "waiver of future capacity"**

   The submission from Dr John Stewart Jones argues that where a person can lose capacity after approval but still proceed with assisted dying, allowing a waiver poses risks. The concerns raised are:

   - People nearing the end-of-life may have fluctuating capacity, potentially leading to an assisted death at a time they might no longer agree to.
   - The waiver could create opportunities for coercion, if others push for the assisted death to proceed once the person has lost capacity.
   - The Terminally Ill Adults (End of Life) Bill does not include a waiver, which the submission claims is because of its perceived risks under existing capacity law. The submission therefore asks the States of Jersey to reconsider including such a mechanism.

The Panel received a submission from Professor the Baroness Finlay of Llandaff[15] who raised concerns about the draft law's approach to decision-making capacity and, in particular, the proposal allowing individuals to waive the final capacity assessment. It states that end-of-life circumstances can significantly affect a person's ability to make decisions, noting that illness, fear, depression, medication and fluctuating cognitive states may all impact capacity. The submission therefore highlights the importance of robust and independent capacity assessments to seek to ensure that decisions are fully informed and voluntary.

A key point made is opposition to allowing individuals to waive the requirement for future capacity. The submission suggests that enabling a waiver could prevent practitioners from identifying any negligence and others' criminal behaviour. It also raises the possibility that coercion, undue influence or abuse could go undetected if a waiver were used to permit an

[15] Written Submission, Baroness Finlay of Llandaff, 10 December 2025

assisted death without contemporaneous confirmation of consent. The submission argues that a best interests assessment would need to be made independently when it is being decided that a waiver is valid to reduce the risk it had been obtained through pressure or manipulation.

More broadly, the submission notes that safeguarding risks, including coercive control, family pressures, financial motives, and emotional vulnerability, underscore the need for caution when relying on waiver of final consent in this context. It also refers to concerns raised in English parliamentary scrutiny, highlighting that some jurisdictions have avoided including a waiver mechanism because of the potential for unsafe or undetected practices under existing capacity laws.

3.3.2 Themes from the Public Hearing with the Minister for Health and Social Services

Survey of Healthcare Practitioners – Willingness to Act Under a Waiver

During the Panel's Public Hearing[16] with the Minister for Health and Social Services, the Panel asked whether the Survey for Healthcare Practitioners which took place in 2025, specifically included the question whether healthcare practitioners were willing to be an administering practitioner and prepared to act in the event that a waiver of future capacity had taken place. The Panel were informed that:

> ***Policy Principal:*** *"They were asked if they would participate on the assisted dying proposals that were approved in P.18, which includes the waiver, but there was not a specific question on their view on the waiver itself."*

The Panel asked the Minister if he was confident that there had been sufficient discussion regarding the waiver. The Minister informed the Panel that:

> ***The Minister for Health and Social Services:*** *"If in the consultation the waiver was there and they subscribed to it, subject to the waiver, then I personally would be. You have asked for my opinion on that and that would be my opinion."*

Distinguishing Meaningful Refusal from Involuntary Movements

The Panel asked the Minister about Article 9 of the draft law, which states that the Administering Practitioner must stop the administration of the substance if the individual shows refusal or resistance through words, sounds, or gestures, while reflexive or involuntary movements are not to be interpreted as gestures. The Panel noted that this provision raised a sensitive practical issue: in situations where an individual makes a movement during the procedure, it may be difficult to distinguish whether the movement is a meaningful indication of refusal or simply an involuntary response. The Panel therefore asked the Minister whether this ambiguity could undermine the principle of personal autonomy, given the risk of misinterpreting or failing to interpret a patient's intentions at a critical moment. The Minister appreciated the *difficult territory* however noted that on balance, he was comfortable with it as it stands. The Panel further asked:

> ***Deputy P.M. Bailhache:*** *"On balance you are prepared to take the risk that somebody might die who did not wish to die?"*

[16] Transcript – Public Review Hearing with the Minister for Health and Social Services – 19 November 2025

> ***The Minister for Health and Social Services:*** *"If they have gone through the entire process saying that they wish to die and they have signed a waiver to the effect that if they become unconscious and they are not likely to come round again, that they wish to have that administered, then I do not think it is humanly possible to go any further down the line of an absolute decision. You asked me the question: am I personally comfortable with that? I am afraid I am. I understand that will offend some people and please some people and I think we are at the point where that is always going to be thus. We are not going to please everybody, and I do get that."*

Risk of a Person Changing Their Mind After Signing a Waiver

The Panel further asked about the risks associated with the waiver of future capacity. The Panel highlighted evidence from other jurisdictions showing that a proportion of individuals who are approved for an assisted death later change their minds and raised concerns that a person who had signed a waiver could lose the ability to communicate this change of mind. The Minister responded that, in most anticipated cases, individuals choosing a waiver were likely to lose capacity as part of a broader decline involving heavy medication and unconsciousness, and suggested that the likelihood of someone changing their mind but being unable to express it was extremely low.

Whether Practitioners Might Encourage Use of a Waiver

The Panel also asked whether practitioners might routinely encourage individuals to sign a waiver as part of the process. The Minister indicated that information about the waiver would be provided in the guidance, but practitioners should not promote or prompt individuals to sign it. Officers explained that at Step 6, the person must make their final request and demonstrate capacity and voluntariness before a waiver can be accepted. They noted that capacity at the end-of-life often fluctuates, and the draft law was designed to allow practitioners to make real-time decisions about whether the individual appeared willing to proceed on the day.

Loss of Ability to Communicate but Retention of Capacity

The Panel explored scenarios where a person could lose the ability to communicate but retain mental capacity and raised concerns that such an individual might not be able to indicate dissent. Officers stated that under the draft law any gestures of refusal, however minimal, would be sufficient to halt the process and emphasised that practitioners could pause proceedings until clarity was established. They also explained that a waiver could be withdrawn at any time prior to the assisted death.

Cases Involving Uncertainty or Distress in Other Jurisdictions

The Panel referred to reported cases in other jurisdictions where uncertainty over gestures or distress had led to investigations. Officers responded that the draft law required practitioners to stop the procedure at any sign of refusal or distress, which they considered an important safeguard.

Rationale for Including the Waiver Despite Low Use Internationally

Finally, the Panel asked why the waiver remained necessary given that evidence suggested only a very small proportion of people in other jurisdictions chose to use one. The Minister stated that, despite the low numbers, it was important to include the waiver to accommodate those individuals who wished to ensure their request could proceed if they lost capacity shortly before the scheduled date.

Further Clarification Provided by the Minister After the Hearing

After the hearing, in follow-up-up correspondence[17] the Minister for Health and Social Services provided further clarification on how the waiver of future capacity would operate under the draft law. It was confirmed that the waiver could be used by an individual whose terminal illness had been approved for assisted dying and who, at Step 6, had the capacity to make both a final request and an informed decision to sign the waiver. Once signed, the waiver would allow the assisted death to proceed even if the individual later lost capacity, including in situations where that loss resulted from sedatives, or medication taken to manage symptoms prior to the practitioner's arrival. The Minister stated there was no reason to prohibit such scenarios, as the earlier assessment process sought to ensure the request was voluntary, settled and informed.

The Minister explained that the waiver did not remove the right to withdraw consent. An individual could communicate refusal verbally or through gestures at any point immediately before the administration of the approved drugs, and the practitioner would be legally required to stop. However, the Minister acknowledged that no safeguard could prevent the possibility of "non-communicated refusal" where a person had lost all ability to express dissent. Officers argued that, in practice, a person who had deteriorated to the point of being unable to communicate would be unlikely to retain the cognitive capacity required to revisit such a complex decision. The Officer further explained:

> ***Chair, End-of-Life Partnership Group:*** *"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."*[18]

The Minister advised that the inclusion of the waiver had been informed by ethical discussions with healthcare professionals and assisted dying practitioners in other jurisdictions, who reported distress caused when an assisted death could not be carried out because capacity had been lost shortly before the scheduled date. The Minister considered the waiver ethically and legally appropriate, noting that Law Officers had confirmed its compatibility with the European Convention on Human Rights.

Regarding safeguards, the Minister highlighted that the assisted dying process involves multiple assessments of voluntariness and settled intention, with practitioners required to verify capacity at the point of signing the waiver. Detailed guidance would set out how practitioners must explain the implications of the waiver to support informed decision-making. The Minister also noted that only very small numbers of people use waivers in other jurisdictions, but emphasised that the provision served an important purpose for those who may experience sudden loss of capacity shortly before the assisted death.

3.3.3 Expert Advisers Findings on Decision-making Capacity and the Waiver

The expert advisers highlighted that the draft law adopts a more stringent approach to decision-making capacity than the standard test under the Capacity and Self-Determination (Jersey) Law 2016. While the draft law mirrors the same five-part capacity test, it requires assessing doctors to *determine* capacity specifically in relation to the decision to end one's life.

[17] Letter from the Minister for Health and Social Services to the Chair of the Assisted Dying Review Panel, 04 December 2025

[18] Transcript – Public Review Hearing with the Minister for Health and Social Services – 19 November 2025 p.48

Unlike the usual presumption of capacity, where capacity is assumed unless evidence indicates otherwise, the draft law allows the assumption of capacity to be made only after the doctor has conducted an assessment and found no evidence of incapacity. This amounts to a "post-assessment" assumption of capacity, rather than a presumption that exists at the outset.

The advisers noted that this represents a significant departure from normal professional practice and will require tailored training for assessing doctors. They welcomed the intention for guidance and training materials to explicitly address this requirement, including modules on assessing capacity within the assisted dying context.

They further observed that this modified assumption of capacity reduces the automatic weight typically given to patient autonomy and introduces an inconsistency with how capacity is approached for other end-of-life decisions. However, the advisers also emphasised that this approach provides an additional safeguard, ensuring that every individual requesting assisted dying undergoes a thorough capacity assessment. Where uncertainty remains, the draft law requires assessors to seek additional professional opinions - an important safeguard highlighted in stakeholder submissions.

The advisers noted that the provision of the waiver supports an individual's autonomy while they still have decision-making capacity, even in situations where that capacity is expected to decline quickly. However, similar provisions are largely absent from most other assisted dying legislation. The advisers further noted that while the waiver of future capacity in the draft legislation does not function as an advance decision, its ultimate legal effect is comparable to an advance decision and is likely to encounter similar difficulties to jurisdictions that permit advance decisions on assisted ding, when clinicians are allowed to administer assisted dying to a person who no longer has capacity. Nevertheless, the advisers stated, there is a strong ethical argument in favour of including such a waiver. It helps prevent individuals who fear imminent loss of capacity from feeling pressured to access assisted dying prematurely. Instead, it allows them to live longer without forfeiting the right to the assisted death they have consciously chosen to arrange, thereby reinforcing personal autonomy and decision-making capacity, even in situations where that capacity is expected to decline quickly. However, similar provisions are largely absent from most other assisted dying legislation.

The advisers, in alignment with the Panel, observed that the members of the Jersey Citizens' Jury[19] were not asked to consider a waiver of final consent. Instead, the Jury was asked whether the legislation should provide for an advance directive permitting a request for assisted dying to be acted upon after a person has lost capacity.

According to P.18/2024, the Phase 1 consultation feedback indicated *limited overall support* for the inclusion of such a waiver. The report further states that there was strong support (83%) *among those who were already supportive of the principle of assisted dying*. However, while a significant proportion of respondents who favoured assisted dying expressed strong support for a waiver, the Advisers' note that this does not constitute evidence of wider islandwide support for a waiver of future capacity or final consent.

[19] Involve (2021) 'Should Assisted Dying be Permitted in Jersey, and If So, Under What Circumstances? Final Report from Jersey Assisted Dying Citizens' Jury', p.25.

The advisers highlighted that recent assisted dying proposals in England[20], Scotland[21] and the Isle of Man[22] do not provide for a waiver of final capacity to consent or for the use of advance directives. All three jurisdictions require individuals to retain decision-making capacity throughout the process.

By contrast, Jersey's draft law would allow an administering practitioner to proceed where a person has lost capacity and has previously waived the requirement for future capacity, provided the individual does not demonstrate refusal or resistance at the point of administration.

The advisers further noted that Canadian data does not indicate whether any practitioners declined to administer assisted dying under a waiver of consent, although most such cases were carried out by family physicians. This suggests that general practitioners were willing to act under a waiver in Canada. In Jersey, however, the healthcare workforce is significantly smaller. While some GPs may be willing to serve as administering practitioners, it cannot be assumed that all would be prepared to do so in cases involving a waiver. The Panel concurs with this and considers it important to determine what proportion of Jersey-based healthcare professionals would be willing to undertake the administering role specifically in scenarios involving a waiver of final consent.

The Panel notes the advisers' view that, while the consultation undertaken to date provides some reassurance, it does not demonstrate clear public support for a waiver of future capacity, nor does it confirm that practitioners would be willing to administer the approved drugs in circumstances where such a waiver is applied. The advisers also highlight that it remains unclear whether any consultation has taken place with Canadian practitioners who have directly managed cases involving a final waiver of capacity. The advisers conclude that, although the proposed amendment to P.18/2024 - to extend the waiver to the requirement for future capacity at Step 7 - would strengthen the practical operation of the waiver, significant safeguarding concerns persist. These concerns relate primarily to the practical and ethical challenges of acting in the absence of a final confirmation of consent, which require careful consideration as the proposals are developed further.

3.3.4 Panel's Observations

The Panel is pleased to note that the Minister has brought forward a series of amendments[23] in response to recommendations (9 &10) made by the Panel's independent advisers concerning the operation of Step 6 of the assisted dying process. The advisers had highlighted that the draft law, as originally lodged, did not sufficiently clarify whether the act of making a final request for assisted dying and the act of waiving the requirement for future capacity were two separate decisions or part of the same single decision. The Minister has confirmed that they are, in practice, inseparable and constitute a single decision.

The Panel is further pleased to note that the Minister's amendment also incorporates a change to deleting column three in the table set out in Article 36(1) which would give effect to the recommendation (6) made by the Panels advisers that the draft law should provide clarity that registered assisted dying practitioners who are willing to be administering practitioners can choose to refuse to be an administering practitioner where a waiver of future capacity is in place.

[20] Terminally Ill Adults (End of Life) Bill [as brought from the Commons]
[21] Assisted Dying for Terminally Ill Adults (Scotland) Bill [as amended at Stage 2], SP Bill 46A.
[22] Assisted Dying Bill 2023
[23] Draft Assisted Dying (Jersey) Law 202- (P.65/2025): Second Amendment

The Panel makes the following key findings and recommendations.

Key Findings

KEY FINDING 10: The assessment of decision-making capacity in assisted dying requires enhanced, context-specific safeguards. The Capacity and Self-Determination (Jersey) Law 2016 may not be sufficient for decisions involving intentionally ending life. Stakeholders emphasised that end-of-life circumstances, fluctuating cognition, emotional distress, and medication all complicate capacity assessments. The draft law's requirement that capacity must always be actively assessed (rather than presumed) adds an important layer of protection but will require clear training and guidance to be applied consistently.

KEY FINDING 11: Serious concerns exist about the risks and ethical complexity of the waiver of future capacity. The evidence shows consistent concerns that allowing assisted dying to proceed after a person has lost capacity may create risks of acting contrary to the person's final wishes, especially where capacity fluctuates or declines unexpectedly. Stakeholders noted that coercion, undue influence, or changes of mind may go undetected once capacity is lost. Internationally, most assisted dying regimes do not include such waivers, reflecting caution about proceeding without contemporaneous consent.

KEY FINDING 12: Practitioners' willingness and preparedness to act under a waiver remains unknown and may affect feasibility. The survey of healthcare practitioners did not ask whether they would be willing to administer assisted dying under a waiver. Expert advisers highlighted that, unlike Canada where the law permits a waiver of final consent, Jersey has a small clinical workforce, making it essential to understand whether a sufficient proportion of practitioners would undertake this role. Without this information, the operational viability of the waiver remains uncertain.

KEY FINDING 13: Distinguishing refusal from involuntary movement is a recognised safeguarding challenge. The Panel's hearing highlighted practical and ethical risks where an individual loses the ability to communicate clearly or makes ambiguous movements during the procedure. While the draft law requires practitioners to stop at any sign of resistance, stakeholders noted that uncertainty may still arise, with potential consequences for autonomy and safety.

KEY FINDING 14: The waiver supports autonomy for some individuals but increases safeguarding complexity. Expert advisers noted ethical benefits for those who fear imminent loss of capacity, allowing them to avoid premature access to assisted dying. They also identified that the waiver functions similarly to an advance decision, bringing with it the same risks recognised internationally: difficulty verifying contemporaneous consent, potential for coercion, and challenges for clinicians administering life-ending medication to a now-incapacitated person.

KEY FINDING 15: Additional training, clearer guidance, and further consultation are required before the waiver can be safely implemented. The Panel's review found gaps in guidance on how practitioners should apply the waiver, manage fluctuating capacity, identify dissent, and navigate substitute decisions. The Panel identified the need for:

- further practitioner surveys,

- renewed public consultation on support for the waiver,

- specific training for administering practitioners, and

- clear guidance for how to proceed if a person still has capacity on the scheduled day or wishes to pause the process.

Recommendations

RECOMMENDATION 10: Due to the proportion of practitioners who would be willing to administer the approved drugs in cases where a waiver is exercised not being identified through the survey conducted in early 2025, there should be a further survey to ascertain this. The aim of which being to enable feasibility of the implementation of the waiver of future capacity. The Minister for Health and Social Services should undertake this further survey during the implementation stage of the draft law.

RECOMMENDATION 11: The Minister for Health and Social Services should, during the implementation stage of the draft law, ascertain through further public consultation whether there is clear public support for a waiver of future capacity and final consent.

RECOMMENDATION 12: The Minister for Health and Social Services should ensure that the training for administering practitioners covers the practical complexities of the waiver of future capacity and final consent.

RECOMMENDATION 13: The Minister for Health and Social Services should ensure that guidance should include that if a registered assisted dying practitioner is not willing to perform an assisted death where there is a waiver of future capacity, they should make this clear at Step 6 when such a waiver is exercised, so that appropriate planning is possible.

RECOMMENDATION 14: The Minister for Health and Social Services should ensure that guidance for assessing doctors should stipulate what the effect will be on the waiver of the requirement of future capacity if the individual still has capacity on the date set for the occurrence of the assisted death and wishes to pause the assisted dying process. It should also be specified whether, in this event, a new waiver would be required.

3.4 Safeguards: Coercion

Coercion is not defined within the draft law however it does provide essential indicators of possible coercion:

- *"Excessive deferment by the person to their carers, family or friends for answers, reassurance or explanation*
- *Carers, family or friends talking over the person and answering on their behalf*
- *Inconsistencies in the person's answers to questions about their suffering, illness experience or assisted dying in general*
- *Inconsistencies between what the person says in private to the assessing doctor, and what the person says in the presence of others."*[24]

[24] Draft Assisted Dying (Jersey) Law 202- (P.65/2025): Addendum – Page 43

The NHS England defines coercive behaviour as: "*continuing act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.*"[25]

This section of the report will outline and analyse how the draft law safeguards against, mitigates and penalises coercion.

3.4.1 Concerns raised in Written Submissions

Safeguarding Framework and Oversight Mechanisms

During the Panel's review, a number of submissions were received which referred to coercion. The Jersey Care Commission[26] stated that safeguarding against coercion is a central concern within any assisted dying framework, and emphasised that strong oversight mechanisms are essential to protecting both individuals seeking assisted dying and the professionals involved in providing it.

The submission noted that the draft law includes numerous safeguards, such as strict eligibility criteria, voluntary participation for healthcare professionals, medical confirmation procedures, independent review, and regulatory oversight by the Jersey Care Commission - which are viewed as important protections against coercion. It welcomed the fact that these safeguards are embedded in primary legislation, as this ensures that any future amendments would require full legislative scrutiny, thereby reducing the risk of incremental expansion without appropriate oversight.

However, as mentioned in the previous chapter (see 2.3), the submission suggested that the safeguarding framework could be strengthened further with the explicit requirement for palliative care specialists to be involved in assessments, ensuring that individuals fully understand and explore all alternative care options before proceeding. This, it argued, would help support informed decision-making and reduce the risk that individuals may feel pressured (implicitly or explicitly) into choosing assisted dying due to a lack of awareness of available palliative pathways.

More broadly, the submission stated that the draft law's ethical principles of dignity, compassion, and non-coercion appear appropriately reflected in the legislation, but reiterated that vigilance around coercion must remain central to the operationalisation of the service.

Indirect and Internal Pressures Identified by Clinical Stakeholders

The Royal College of Psychiatrists[27] stated that psychiatrists can contribute to identifying potential coercion in their own patients, but the profession does not hold specialist expertise in coercion assessment more broadly. The College emphasised that coercion must be considered in a comprehensive manner, including indirect or internal pressures such as feeling a burden, financial stress, or insufficient social support. It noted that while no assessment can

[25] NHS England » Coercion
[26] Witness Submission, Jersey-Care-Commission, 4th November 2025
[27] Witness Submission, Royal College of Psychiatrists, November 2025

conclusively exclude coercion, a robust and thorough process can improve the likelihood of detecting it.

Heightened Vulnerability in Certain Cohorts

Dr John Stewart-Jones from the Dying Well Group[28] stated that notwithstanding the proposed training for the two assessing physicians, the risk of coercion cannot be entirely eliminated. The submission observed that coercion may originate from third parties seeking personal gain or from internalised pressure within the individual, including feelings of being a burden to carers or family members. The submission further stated that, in Oregon, "*feeling a burden*" has been recorded as a motivating factor for a substantial proportion of applicants for assisted dying or assisted suicide.

The submission stated that certain cohorts may face heightened vulnerability, including individuals with conditions associated with increased suicidal ideation—such as bipolar disorder, anorexia nervosa, and autism—particularly where these coexist with physical illness. It further stated that treatable depressive and anxiety symptoms may accompany physical illness and expressed concern that the draft law contemplates eligibility where fear of potential future suffering is present, irrespective of clinical likelihood.

The submission stated that persons considering assisted dying should be encouraged to undergo assessment by both an appropriate medical specialist and a palliative care specialist, in order to obtain a more accurate understanding of probable disease trajectories, symptom burden, and treatment implications.

Finally, the submission stated that these proposed assessment measures could, in certain circumstances, intersect with or appear to conflict with the draft law's prohibition on coercively or dishonestly inducing a person to request, proceed with, or withdraw from assisted dying.

Concerns About Abuse, Undue Influence and Family Dynamics

Professor the Baroness Finlay of Llandaff[29] provided a submission which stated that safeguarding against coercion must be a central consideration in any assisted dying framework, and that safety should take precedence over ease of access to lethal drugs. It emphasised that all eligibility assessments must examine in detail the reasons a person is seeking an assisted death, with specific attention to potential coercive behaviours by others, including undue influence, pressure, persuasion, and various forms of abuse—particularly financial abuse, coercive control, and emotional neglect within families. The submission also highlighted concerns that motivations related to inheritance or the concealment of medical error could influence decisions and may go undetected without rigorous scrutiny.

The submission further stated that consent must not be waivable in advance and that the requirement for a final assessment of capacity should not be removed. It was argued that allowing waivers would increase the likelihood of undetected negligence or criminal coercion, as coercion may have occurred prior to the signing of any consent waiver. To safeguard against

[28] Witness Submission, Dr-John-Stewart-Jones, 7 November 2025 – Page 1
[29] Written Submission, Baroness Finlay of Llandaff, 10th December 2025

this, the submission suggested that any "best interests" assessment connected to a consent waiver should be undertaken independently.

Additionally, the submission noted that unconscious bias within healthcare could create risks if assessments are conducted by a single practitioner without adequate oversight. It argued that strong scrutiny and monitoring mechanisms are necessary to identify coercion and to ensure that assessments are conducted consistently and safely.

Need for Specialist Capacity and Coercion Expertise

The Panel also received a submission from a member of the public regarding coercion[30]. The submission articulated concerns regarding the suitability of doctors alone undertaking assessments of capacity and coercion within the assisted dying process. It stated that such assessments may be more appropriately conducted—either wholly or in part—by professionals with specific training in mental capacity law and related methodologies. The submission highlighted that, in the author's experience, errors in capacity assessments are common, particularly where assessments are not decision-specific or where the impairment in decision-making is not properly linked to an impairment of mind or brain. These errors, it was argued, can leave decisions vulnerable to challenge.

The submission expressed concern that, without specialist expertise, individuals who lack capacity might incorrectly be deemed eligible under the proposals, and conversely, individuals who do have capacity might be wrongly excluded. It therefore questioned the extent to which the Panel has considered involving a broader range of trained professionals in assessing informed and voluntary consent.

Finally, the submission asked how the Panel and Government would assure themselves that individuals are receiving a high-quality assessment service and referenced research indicating poor practice in capacity assessments among clinicians.

3.4.2 Themes from the Public Hearing with the Minister for Health and Social Services

During a public hearing[31], the Panel questioned the Minister for Health and Social Services and his officers on how the draft assisted dying framework addresses coercion.

Guidance for Healthcare Professionals

The officers stated that the professional guidance will not provide a single, fixed definition of coercion. Instead, it will set out indicators of possible coercion, describe the forms it can take, and outline the dynamics and power imbalances in which coercion may occur. They emphasised that coercion could manifest in multiple ways, including subtle or indirect pressure.

Assessment of Voluntariness

The Director of Health Policy explained that the law requires the assessing doctor to be positively

[30] Written Submission, Mark-Leeman, 6th October 2025
[31] Transcript – Public Review Hearing with the Minister for Health and Social Services – 19 November 2025 – Page 35

satisfied that the person's decision is voluntary and free from coercion. This is described as a *high bar*, and the obligation rests on demonstrating voluntariness rather than merely failing to uncover coercion. If the doctor has doubts or is unable to make this determination, the person cannot be found eligible.

Limitations on Family Contact and Related Risks

The officers noted that a person may request that the assessing doctor does not speak to family members. While permissible under the law, this situation is recognised as increasing the potential risk of coercion. In such cases, the doctor must inform the individual that restricting access to family may prevent them from completing the assessment, as the doctor must still be satisfied of voluntariness.

Cross-Government Training on Coercion

The Panel raised concerns about the wider context of coercion, referencing the Violence Against Women and Girls (VAWG) taskforce work, where training needs analyses, and training around coercion, had not yet been completed across some agencies. The Director of Health Policy confirmed that all assisted dying practitioners will be required to undertake coercion-related training, and that optional training must also be made available more broadly. She added that it would be incumbent upon the Minister to ensure strong uptake across the wider care workforce.

Future Cross-Departmental Collaboration

When asked whether the Minister would engage with the Minister for Home Affairs to explore opportunities for joint working around coercion and safeguarding, the Minister stated that he would be willing to initiate such conversations.

During the hearing[32], the Panel raised concerns brought forward by some Islanders with disabilities, specifically relating to the risk of coercion or perceived pressure to opt for assisted dying. The Panel sought clarification on how the legislation protects disabled people from such risks. The Minister acknowledged that consultation feedback showed a range of views among disabled Islanders. He noted that while some expressed concern about potential coercion, others felt strongly that disabled people should not be spoken for by others or treated as a uniform group requiring exceptional protection. Several disabled respondents emphasised their desire to be treated as individuals with the same rights as others, including the right to request an assisted death.

The Director of Health Policy explained that the legislation contains "hardwired" safeguards applicable to all individuals, including those with disabilities. These included:

- A requirement that assessing doctors must be satisfied—at every step—that the person's wish is voluntary and free from coercion.
- Mandatory training for all assisted dying practitioners, with a strong emphasis on identifying signs of coercion.

[32] Transcript – Public Review Hearing with the Minister for Health and Social Services – 19 November 2025 – Page 6

- Additional measures adopted following consultation concerns, including the establishment of multidisciplinary teams. These teams will include professionals such as social workers who have expertise in recognising coercion and safeguarding risks.

It was also emphasised that the law includes specific offences relating to coercion, carrying severe penalties. In addition, the legislation includes offences prohibiting the promotion of assisted dying to specific groups, including disabled people. These provisions were introduced in recognition of concerns raised in other jurisdictions about targeted promotion or undue influence.

3.4.3 Expert Adviser Findings on Coercion

The expert advisers[33] highlighted coercion as a central risk to be addressed within any assisted dying framework, noting that concerns often focus not only on overt pressure but also on subtle dynamics that may undermine voluntariness. While "coercion" is commonly associated with force, threats, or compulsion, contemporary analyses emphasise that the forms of influence most relevant to assisted dying are frequently less visible. As Belshaw observes, assisted dying debates are shaped by apprehension about "illegitimate influence – effective yet often disguised – on someone's actions", which may operate through relational, emotional, or situational pressures rather than explicit threats.

Comparative guidance from other jurisdictions reinforces this wider conception. For example, Austria's practical guide to its assisted dying law explains that psychological or physical pressure exerted by relatives may prevent a decision from being free and self-determined. It notes that a situation of pressure may be assumed where a person's essential motive appears to stem from the interests of another party, including emotional, economic, or financial considerations. Similarly, guidance for clinicians in South Australia defines coercion broadly as persuading someone through dishonesty, force, or threats, framing "abuse" in this context as inherently including coercion. These approaches reflect a shared recognition that coercion can be subtle, relational, and embedded within everyday interactions, and that safeguarding processes must therefore be designed to detect a spectrum of potential influences.

The advisers note that a significant aspect of this issue is the role of "burden self-perception" - a person's belief that they have become a burden to others, which is frequently cited in jurisdictions where assisted dying is available. In Oregon, for instance, 46.6% of individuals who accessed assisted dying between 1998 and 2024 identified being a burden on family, friends, or caregivers as one of their end-of-life concerns. The Expert Advisers emphasised that while such feelings may be genuinely held, they must be carefully distinguished from external pressure. Health care professionals responsible for assessing eligibility need to be able to explore the relational context surrounding a person's request, recognising the influence of factors such as financial strain, caregiving dynamics, and social isolation.

Evidence from Variath et al.'s scoping review indicates that clinicians in permissive jurisdictions already undertake comprehensive evaluations of patients' values, motivations, and sources of distress to seek to ensure requests are voluntary and informed. Assessors must also remain alert to the ways in which a person's sense of burden may intersect with other pressures, from

[33] Expert Advisers report - Review of the Draft Assisted Dying Legislation

supportive reassurance by relatives to more coercive dynamics, recognising that such influences can increase or reduce the impact of burden self-perception. As scholars note, autonomous individuals are embedded within social relationships that can shape decision-making both implicitly and explicitly, requiring sensitive exploration of the broader context.

Systematic reviews reinforce the complexity of this area. One review of nine studies involving 219 patients found that burden self-perception is not a fixed or transient feeling but rather a fluctuating process shaped by numerous interacting factors. The authors conclude that it requires ongoing assessment rather than a single determination at a point in time. Another review of fourteen qualitative studies stresses the individualised nature of these feelings, arguing that they cannot be understood without reference to the person's biographical background, their interpretation of dependency, and their relationship to care. This underscores the need for safeguards that recognise the dynamic and deeply personal character of burden self-perception.

3.4.4 The Panel's Fifth Amendment - Offences Relating to Coercion

The Panel proposes an amendment[34] to the draft law to clarify and strengthen the criminal law response to coercion within the assisted dying pathway.

A proposed revision to Article 45 reflects the Panel's careful assessment of the terminology required to establish an offence that is both practicable in legal terms and aligned with the moral purpose of safeguarding genuinely autonomous decision-making. The substitution of "dishonestly" with "maliciously" offers a clearer threshold for criminal liability and avoids unintended consequences for practitioners and those offering legitimate support.

A new Article 46 (Offence to coerce decision to not have assisted death) is introduced to deal with coercion aimed at turning someone away from assisted dying, including pressuring someone not to request, not to proceed to a next step, or to withdraw a request. The proposal does not introduce this offence, which already exists in the Minister's draft legislation, but reassesses the penalty to be lower-level and in the form of a fine. This draws a principled distinction between (i) coercing a person into an assisted death (for which the Panel supports retaining the proposed maximum 14-year sentence) and (ii) coercing a person out of the process (for which a financial penalty is proposed). The Panel considers this differentiation ethically justified and aligned with the draft law's structure, where the most serious criminal liability is reserved for conduct that drives a person toward ending their life against their will. Together, these changes sharpen the focus on undue pressure in either direction while ensuring penalties remain proportionate to the nature and gravity of the harm.

The Panel's expert advisers and the wider literature recognise two directions of coercion in assisted dying: pressure to proceed and pressure to desist. The amendment explicitly addresses both, while adjusting the criminal response to avoid turning sensitive clinical communication into an undue legal hazard. The approach preserves the integrity of multi-step assessments (capacity, voluntariness, and absence of undue influence) by ensuring that criminal liability attaches to wrongful pressure, not to good-faith clinical dialogue or family support.

[34] Draft Assisted Dying (Jersey) Law 202- (P.65/2025): fifth amendment

Comparative analysis presented to the Panel indicates that other jurisdictions criminalise the act of inducing or coercing someone to complete eligibility steps to varying degrees, with graduated penalties:

Victoria (Australia) and Western Australia - offences capture dishonesty/undue influence to induce requests or self-administration, with penalties ranging from 5 to 7 years, and higher where the conduct facilitates self-administration.

Oregon (USA) - treats certain coercive or falsifying conduct as a Class A felony (up to 20 years).

The Australian Capital Territory (ACT) - now distinguishes between inducing a person to make a request (imprisonment up to 7 years) and inducing a person to revoke a request (a fine denominated in penalty units).

The Panel's proposal mirrors this directional nuance and reflects this distinction by recognising that coercion encouraging an assisted death and coercion discouraging an assisted death are different in nature and require different legal responses; and by reserving the highest penalties for the most harmful outcome - coercion into assisted death.

The Panel believes these amendments strengthen safeguards against coercion in a way that is ethically grounded, consistent with international comparators, and mindful of clinical realities. They reinforce the principle that decisions within the assisted dying pathway must remain voluntary, informed, and free from undue influence, while ensuring the criminal law targets genuinely culpable pressure with proportionate sanctions.

3.4.5 The Panel's Fourth Amendment – Removal of Third Party Appeals

The Panel proposes an amendment[35] to remove appeals by a person with a "special interest"[36] against *positive* eligibility decisions. This would ensure that only the applicant may challenge decisions, aligning the appeals framework with the draft law's patient-centred safeguards.[37]

The Panel considers that allowing appeals by persons with a "special interest" can create a vector for coercion or undue influence, particularly within family dynamics marked by conflict, dependency, or contested values. A third-party avenue to litigate a positive eligibility decision introduces an adversarial lever at a highly vulnerable point for the applicant, potentially exerting pressure to delay, deter, or reverse the applicant's autonomous choice. It may also necessitate wider disclosure of sensitive clinical information to justify or defend a clinical decision, thereby intensifying interpersonal leverage and risk of relational coercion. The amendment is designed to close this potential pressure point while leaving intact all clinical and governance safeguards against coercion within the eligibility pathway.

The Panel's expert advice indicates that third-party appeals against positive eligibility decisions are exceptionally rare, with only one comparator identified - Queensland, Australia. A form of third-party review is permitted by the Queensland Civil and Administrative Tribunal (QCAT). QCAT may review decisions upon request by the applicant, their agent, or another person with a

[35] Draft Assisted Dying (Jersey) Law 202- (P.65/2025): fourth amendment

[36] A person who the Court is satisfied has a special interest in a particular individual's care and treatment (such as certain connected people or professionals involved in the individual's assisted dying process) – Article 42

[37] The Panel agreed this amendment by majority, with Deputy Bailhache recording his dissent.

"sufficient and genuine interest" (e.g., a spouse, close family member, carer, or member of the healthcare team). Even there, no reported cases were found of relatives or others appealing a positive decision, nor evidence of problems arising from the review framework. The majority of jurisdictions permitting assisted dying do not allow appeals by anyone other than the applicant.

The Panel's advisers cautioned that a third-party appeal right may amount to an unjustified interference with a capacitated adult's private life and autonomy under Article 8 ECHR. In the context of coercion, forcing a patient into a defensive legal position (potentially against family or others) can compound vulnerability and amplify pressure to abandon their stated wishes.

The Panel notes that the draft law already proposes the following safeguards which the Panel considers are sufficient:

- two independent medical assessments
- capacity assessments and examination for coercion
- multiple procedural steps and defined decision points
- oversight of clinical governance, service safety, and quality by the Assisted Dying Delivery and Assurance Committee.

The Panel found no safeguarding gap that would be filled by third-party appeals.

By removing third-party appeals, the amendment protects the integrity of the clinical pathway, preserves confidentiality, and prioritises the applicant's autonomous decision, while the established capacity and anti-coercion checks continue to operate as the primary safeguards.

The Panel concludes that third-party appeals are not necessary to prevent coercion and in fact risk facilitating coercive dynamics by enabling adversarial interventions at a late stage. The amendment aligns Jersey's model with international norms, reduces coercion risk, and preserves a clear, clinically led pathway in which only the applicant may seek review of decisions that directly affect their rights and care.

3.4.6 Panel's Observations

The Panel considers coercion to be one of the most significant safeguarding risks within any assisted dying framework. Across written submissions, expert evidence, and the Public Hearing with the Minister, a consistent theme emerged: coercion is rarely overt and may be subtle, relational, emotional, or internalised. The Panel agrees that safeguarding measures must therefore address a wide spectrum of influences, including undue pressure from others, complex family dynamics, financial motives, internal feelings of burden, and the broader social context surrounding end-of-life decision making.

The evidence demonstrates that while the draft law contains multiple strong safeguards, there remain opportunities to strengthen clarity, accountability, and resilience in the system. Written submissions highlighted concerns about the adequacy of professional expertise, the complexity of capacity assessments, the particular vulnerabilities faced by some cohorts, and the importance of involving practitioners trained in identifying coercive control. The Expert Advisers emphasised the need for assessors to understand subtle psychological pressures, fluctuating emotions, and the relational context of decision making.

The Panel concludes that safeguarding against coercion requires rigorous assessment, strong professional guidance (see Chapter 4), clear, proportionate legal protections (as proposed by the Panel's Fourth and Fifth Amendments), and multidisciplinary expertise. Assessments for assisted dying must draw on a broader range of professional expertise than medical training alone can provide. Clinicians, while central to the process, may not always have specialist knowledge of coercive control, safeguarding dynamics, or complex capacity assessment.

The Panel makes the following key findings and recommendation.

Key Findings

KEY FINDING 16: Coercion is multifaceted, often subtle, and requires safeguards that address both external and internal pressures. Evidence consistently demonstrates that coercion rarely presents as overt force. Instead, it may arise through emotional dependence, family dynamics, perceived burden, financial pressures, or relational influence. Safeguards must therefore be designed to detect a wide spectrum of both visible and hidden pressures.

KEY FINDING 17: Certain groups face heightened vulnerability to coercion and abuse, requiring enhanced assessment and specialist expertise. Submissions identified that individuals with mental health conditions, neurodivergence, sensory impairments, diverse personal characteristics or complex social environments may be at particular risk of internalised pressure or undue influence. This reinforces the need for specialist training, careful capacity assessment, and contributions from practitioners with wisdom and expertise in safeguarding, mental health and social care.

KEY FINDING 18: Strong procedural safeguards exist in the draft law, but key gaps remain, particularly around professional expertise, assessment consistency and risk management. While the draft law includes multiple layers of checks (two assessments, voluntariness tests, offences for coercion, prohibitions on promotion of assisted dying, and independent oversight) stakeholders and expert advisers highlighted the need for clearer guidance, specialist training and multidisciplinary involvement to enable these safeguards to operate effectively in practice.

KEY FINDING 19: Effective safeguarding against coercion relies on multidisciplinary assessment, not medical evaluation alone. Across all evidence, a common theme emerged: clinicians cannot realistically be expected to identify all forms of coercion without input from safeguarding professionals, mental capacity specialists and social care practitioners. Multidisciplinary assessment was highlighted as essential for recognising subtle relational pressures, improving consistency, and strengthening public confidence.

Recommendations

RECOMMENDATION 15: The Minister for Health and Social Services should ensure that eligibility assessments for assisted dying are supported by a multidisciplinary team, including safeguarding professionals, mental capacity specialists, and social care practitioners, so that coercion-related risks are examined from multiple professional perspectives. The aim of which

being to strengthen the robustness of assessments, improve consistency, and enhance public confidence by ensuring that decisions are informed by a comprehensive understanding of the person's social context, vulnerabilities, and potential sources of undue influence.

3.5 Funding and implementation costs

The establishment of an assisted dying service[38] will carry both financial and resource implications, including the need for dedicated funding, initial setup expenditure, and the recruitment and staffing required to operate the service. This position is consistent with the original in-principle decision of the States Assembly (P.95/2021), which noted that "an assisted dying service would require the provision of additional funding within a future *Government Plan.*"[39]

This section considers the funding and implementation costs of an Assisted Dying Service. The Panel wrote to 20 financial experts to receive informed submissions however notes that it only received one expert submission.

In the Budget 2026-29[40] (hereafter 'the Budget') annual funding for up to four years was approved for the Assisted Dying Service, this funding was largely allocated to implementation costs. The estimated funds allocated were:

Growth Allocations

Expenditure Growth Allocations				
£'000	2026 Estimate	2027 Estimate	2028 Estimate	2029 Estimate
Assisted Dying	525	727	688	718

3.5.1 Concerns raised in Written Submissions

The Panel notes that Dr John Stewart-Jones, representing the Jersey Dying Well Group[41], raised several financial and proportionality concerns regarding the proposed assisted dying law.

1. Implementation Costs and Funding Priorities

Dr Stewart-Jones suggested that the projected £2.7 million implementation cost over the first three years is disproportionate given the small number of people expected to access assisted dying. He suggested that this level of investment would have greater impact if directed toward specialist palliative and end-of-life care, which serves a far larger proportion of the population. He also noted that in other jurisdictions the number of assisted dying cases tends to rise over time, which would likely increase future costs, whereas palliative care remains insufficiently funded despite broader need.

[38] Assisted Dying Proposition – P.2 - P.18/2024 – Section 12: Resource and financial implications, risks and next steps
[39] Assisted Dying in Jersey – P.95/2021
[40] P-70-2025 Government-Plan -2026-29
[41] Witness Submission, Dr-John-Stewart-Jones, 7 November 2025 – Page 6

2. Overall Health Funding Pressures

Dr Stewart-Jones highlighted that Health and Community Services must deliver savings exceeding £10 million in 2026, with no funding available for new health initiatives. He drew attention to pressures across mental health, medicine, surgery, social care and several unfunded strategic programmes (including dementia, suicide prevention and neurodiversity). Against this backdrop, he expressed concern that a fully funded assisted dying service could divert resources from essential, life-supporting services used by many more Islanders.

3. Penalties and Safe Access Zones

Dr Stewart-Jones questioned whether the maximum penalty of £10,000 for offences such as coercion related to assisted dying decisions is proportionate, given that potential financial gain for an offender could be substantially higher. He also challenged the need for safe access zones, stating there is no evidence of protests or harassment in Jersey or other assisted dying jurisdictions, and cautioning that such zones may unnecessarily restrict freedom of expression.

A further submission[42] was received from a financial expert with a background in financial management, cost modelling and budgetary assessments, who reserved the right to anonymity. The Panel notes that the financial expert reviewed the proposals focusing on their financial implications and the related allocations set out in the Budget, solely from a financial and operational standpoint, drawing on experience in cost modelling and public-sector budget assessment. The expert concluded that the financial information supporting the draft Assisted Dying Law is indicative rather than fully costed, with several structural gaps that limit confidence in the sufficiency of the proposed budget envelope.

The expert highlighted that the draft law does not set out the underlying assumptions required to assess financial adequacy, such as workforce capacity, administrative infrastructure or governance requirements, and recommended that the legislation be strengthened through a detailed financial impact assessment and sensitivity analysis.

With respect to the proposed budget allocations, the expert considered the estimated £2.66 million over four years to be a credible starting point, but at the lower end of what is likely to be required to establish a compliant and well-governed service. Drawing on evidence from comparable jurisdictions such as Western Australia, the expert observed that early implementation costs are often underestimated, with additional expenditure typically required in years two and three to support governance, specialist training and cross-agency coordination. The expert therefore recommended incorporating contingency funding and scheduled budget reviews as actual cost data emerges.

In their accompanying detailed commentary, the expert identified several weaknesses when tested against established public-sector budgeting standards. These included: a lack of inflationary uplift across staffing and operational categories; no sensitivity testing for variations in uptake or implementation delays; the absence of a contingency provision; and unclear distinction between one-off implementation costs and recurring operational expenditure. The expert also noted that Programme Management Office functions (essential for governance and oversight) had not been separately costed.

[42] Written Submission, Anonymous

Further gaps were observed across specific cost lines including: recruitment costs assumed as one-off rather than recurring; unrealistic assumptions around staffing inflation and replacement; insufficient provision for ongoing training and continuing professional development; underestimation of digital systems costs; and a communications budget unlikely to be adequate for a credible public information campaign.

Overall, the expert concluded that the current budget provides a useful initial framework but reflects an implementation-only view, rather than a full lifecycle funding model. Without adjustments for inflation, contingency, and sustained governance and oversight costs, the expert warned that the programme may be exposed to early cost overruns and longer-term financial pressures. The Panel notes these findings and the expert's recommendation to strengthen the financial model to enable resilience and long-term affordability.

3.5.2 Themes from the Public Hearing with the Minister for Health and Social Services

The Panel joined the Health and Social Security Panel[43] at its Review Hearing[44] into the Proposed Budget to ask a number of questions regarding the funding for Assisted Dying. During the hearing, the Panel sought clarification from the Minister for Health and Social Services and his officers on the projected funding for the assisted dying service. Officers explained that the figures allocated for 2026–2029 (£525k in 2026; £727k in 2027; £688k in 2028; £718k in 2029) are indicative forecasts, based on the best available assumptions. They emphasised that the service is novel, and therefore demand levels, case complexity, and staffing time cannot yet be reliably predicted.

The Panel was advised that the 2026 and part of the 2027 budgets primarily cover implementation and set-up costs, including the appointment of a project manager, development of a bespoke mandatory training package for assisted dying practitioners, recruitment, and the preparation of guidance and operational frameworks. From mid-2027 onwards, the funding begins to shift toward service delivery costs, as the Government anticipates that the first assisted dying requests will begin during that year.

By 2028 and 2029, most of the budget is allocated to ongoing service provision, including practitioner time for assessments, counselling support, and core oversight, audit, and governance functions. Officers noted that, based on trends observed in other jurisdictions, demand for assisted dying may be relatively low initially but is likely to rise over time as awareness of the service grows—accounting for the cost increase from 2028 to 2029.

The Panel also queried how much funding had already been allocated from the Central Reserve. Officers and the Minister confirmed that no funding has yet been allocated directly to Health, as the assisted dying budget is currently held centrally by Treasury and would be drawn down once the service is formally agreed and implementation work progresses. The Director of Health Policy was not able to confirm the exact breakdown of "core costs" underpinning governance functions but undertook to provide this separately.

3.5.3 Panel's Observations

[43] States Assembly | Health and Social Security Panel
[44] Public Hearing Transcript - Health and Social Security Panel - 15 October 2025 – Page 11

The Panel recognises that establishing an assisted dying service will require significant and sustained investment, and that the indicative funding allocated in the Government Plan represents only an initial estimate. The evidence reviewed demonstrates that the true cost of implementation and early operation remains uncertain, with substantial risks of underestimation.

The Panel notes that stakeholders raised concerns about the proportionality of the projected costs when compared with the small number of anticipated users, particularly given wider financial pressures within Health and Community Services. The Panel also acknowledges the expert view that the current model reflects an implementation-only perspective, lacking clarity on long-term governance, workforce, inflationary pressures, digital infrastructure costs, and contingencies.

The Panel further observes that the Minister and his officers confirmed that the figures set out in the Budget are indicative forecasts rather than detailed financial models, and that demand, staffing time and service complexity cannot yet be reliably predicted. While this is understandable for a new service, the Panel considers that proceeding without a robust, fully costed financial impact assessment increases the likelihood of early cost overruns and places avoidable pressure on other health services.

The Panel concludes that while the current budget provides an important starting point, it does not yet constitute a durable or fully evidenced financial plan. Strengthening the financial framework is essential to support the assisted dying service being implemented safely, sustainably, and without unintended consequences for the wider health system.

The Panel makes the following key findings and recommendations.

Key Findings

KEY FINDING 20: The current financial model for an assisted dying service is indicative only and lacks the detailed assumptions needed for a reliable funding plan. Evidence from expert submissions and the public hearing indicates that the Budget 2026–29 allocations are based on early, high-level estimates rather than a fully developed financial impact assessment. Key cost drivers: governance structures, workforce requirements, inflation, training costs, and digital infrastructure - are not yet clearly established, creating a risk of underestimation.

KEY FINDING 21: There are substantial risks of early cost overruns and longer-term financial pressure. A financial expert raised concerns around structural gaps: no sensitivity testing, no contingency provision, insufficient inflation adjustment, unclear distinction between one-off and recurring costs, and underestimation of specialist training, PMO governance and communications budgets. International evidence (e.g., Western Australia) suggests implementation costs often rise in years two and three, reinforcing the need for a more resilient financial model.

KEY FINDING 22: Stakeholders raised concerns about proportionality and competing pressures on the health budget. Written submissions noted that Health and Community Services faces significant financial pressures across core services. Several concerns were raised about whether a funded assisted dying service (expected to serve a small number of individuals) might divert resources from essential, underfunded areas such as palliative and end-of-life care, mental health, social care, and long-term strategies.

KEY FINDING 23: Funding forecasts are uncertain due to unpredictable demand and limited baseline data. Officers advised that demand, staffing time and case complexity cannot yet be reliably forecasted for a new service. The lack of historical Jersey data means assumptions remain speculative, increasing the need for ongoing review and adjustments.

KEY FINDING 24: Stronger financial modelling, transparency and structured review processes are required to establish a sustainable and accountable service. The evidence demonstrates the need for a full financial impact assessment, planned financial review points, and clear breakdowns of governance and core costs. Without these, the long-term affordability and resilience of the service cannot be guaranteed.

Recommendations

RECOMMENDATION 16: The Minister for Health and Social Services should, prior to implementation of the Assisted Dying Service, develop a comprehensive financial impact assessment for the assisted dying service, including detailed assumptions, staffing models, governance structures, and costed operational requirements.

RECOMMENDATION 17: The Minister for Health and Social Services should consider the introduction of contingency funding and scheduled financial reviews, recognising that implementation costs are likely to increase in the early years as the service becomes established.

RECOMMENDATION 18: The Minister for Health and Social Services, in conjunction with the Minister for Treasury and Resources, should ensure transparency in the use of central budget allocations, including a clear breakdown of core governance costs once these are finalised.

4 Training and Guidance

4.1 Background

Training and guidance are central pillars of any safe, ethical, and sustainable assisted dying framework. The Panel's Terms of Reference explicitly require the evaluation of the Draft Assisted Dying (Jersey) Law (P.65/2025) in relation to legal, medical, financial and sustainability implications; ethical considerations; alignment with dignity, safeguarding and freedom of choice; and the adequacy of safeguards for all individuals involved. Training is both a safeguard in itself and the mechanism through which safeguards become operational.

The draft law establishes a statutory foundation for training and guidance through Articles 62, 63, 65, and 66, supported by the detailed operational requirements in the Addendum. Together, these provisions require:

- Mandatory continuing training for assisted dying practitioners (including assessing doctors, certifying doctors, care navigators and administering practitioners) at intervals determined by the Assisted Dying Assurance and Delivery Committee.
- Training covering:

- all elements of the law, including procedural and assessment requirements
- operational guidance
- risk, including domestic abuse, coercive control, financial abuse, and whether someone has been coerced or pressured
- professional safety and well-being
- technical knowledge specific to each role.

- General guidance to be published, including guidance for families and carers, and guidance on identifying coercion and abuse, as well as broader safeguarding considerations.
- Provision of optional additional training to all other health and care professionals (though the Panel notes from the public hearing that uptake would be voluntary unless amended – see section 4.3).
- The Assisted Dying Assurance and Delivery Committee to oversee and set intervals for required training, reinforcing ongoing competency and ethical consistency.

This chapter summarises the evidence received by the Panel regarding the training and guidance required for a safe and ethically defensible assisted dying service in Jersey.

4.2 Evidence Considered on Training and Guidance

4.2.1 General Calls for More Guidance and Clarity

The Panel received submissions expressing concern that training and guidance proposals were not yet fully detailed and that the service would need to "adapt" over time, with guidance evolving as clinical experience accumulates. Stakeholders emphasised that guidance must be practical, comprehensive and sufficiently clear to enable consistency in professional practice, particularly in a small jurisdiction where case volumes are likely to be low and opportunities for experiential learning may be limited.

Stakeholders also stressed the value of advance publication of detailed guidance to enable health and care practitioners, support organisations and regulators can prepare effectively.

4.2.2 Royal College of Psychiatrists (RCPsych) – Training Needs and National Monitoring

In its detailed submission to the Panel, the Royal College of Psychiatrists (RCPsych)[45] emphasised the importance of specialist training for assessing mental disorders, decision-making capacity, and the psychological dimensions of assisted dying requests. The College stated:

> *"Coercion – including indirect or internal forms of pressure, fear of being a burden, financial hardship and inadequate social support – needs to be comprehensively assessed."*

[45] Witness Submission, Royal College of Psychiatrists, November 2025

The College further emphasised that:

- No assessment can *definitively* exclude coercion
- Assessors must be trained to recognise mental disorders (including depression, and dementia), neurodevelopmental conditions and intellectual disabilities) that may impair capacity
- Psychiatric expertise may be required in complex cases.

The RCPsych also welcomed the prospect of national monitoring, noting that jurisdictions with mature assisted dying systems conduct centralised reviews to identify patterns, risks, and emerging safeguarding issues. They encouraged Jersey to adopt similar oversight mechanisms to evaluate the impact of training, guidance and clinical practice over time.

4.2.3 Dr John Stewart-Jones – Coercion, Vulnerability and Limits of Training

In his submission, Dr John Stewart-Jones[46] highlighted the inherent difficulty in identifying coercion, even with extensive training. He warned:

"Even with the proposed training of the doctors involved in assessing the risk of coercion, it is impossible to completely exclude coercion."

He referenced evidence from Oregon indicating that feeling a burden to others has been recorded as an incentive for many assisted dying applicants, suggesting the need for training to cover internalised pressures as well as external coercion. He also identified groups at heightened risk—including individuals with bipolar disorder, anorexia nervosa, autism, or depression, arguing that assessments must be conducted by professionals trained to identify these complexities.

This submission strongly reinforced the need for training that goes beyond procedural instruction and equips practitioners to navigate subtle, clinically complex forms of vulnerability.

4.2.4 General Pharmaceutical Council – Training, Guidance and Regulatory Preparedness

In its submission, the General Pharmaceutical Council (GPhC)[47] emphasised its regulatory role in setting the standards of education and training for pharmacists and pharmacy support staff. The GPhC did not offer a view on whether assisted dying should be introduced in Jersey.

The Council stated:

"If the Draft Law becomes law, we would consider how our standards and

[46] Witness Submission, Dr-John-Stewart-Jones, 7 November 2025
[47] Witness Submission, General Pharmaceutical Council, 5 November 2025

guidance could support pharmacy professionals and pharmacy owners in relation to this change in the law."

It highlighted that it would consider how its standards and guidance on issues such as personal values, religion and beliefs, could support pharmacy professionals and pharmacy owners in relation to a potential change to the law on assisted dying. The GPhC indicated that it would continue to collaborate closely with professional bodies, training providers and regulators to use the powers available to it to achieve its misison of putting safe and effective pharmacy at the heart of healthier communities.

The submission also underscored the need for Government of Jersey-issued guidance or codes of practice to enable the GPhC to understand the specific operational and professional requirements of the service. It noted that such guidance would be essential not only to support training needs but also to help the regulator assess concerns about fitness to practise should these arise within the context of assisted dying. The GPhC also welcomed further information in due course regarding the requirements for education and training, as well as the location and storage requirements of medicines to be used for assisted dying.

4.2.5 Themes from the Public Hearing with the Minister for Health and Social Services

During the public hearing[48] with the Minister for Health and Social Services, Panel members queried:

- How the Government intends to design, commission and deliver mandatory training
- Whether training will be accredited, competency-based and regularly updated
- How professionals will be trained to apply eligibility criteria, including those relating to capacity
- What guidance will be provided to support professionals who conscientiously object while ensuring continuity of access for eligible citizens

The Panel was advised that these details had not yet been developed, however, the Minister acknowledged the need for detailed professional guidance, noting that the operational framework will be developed during the 18-month implementation period.

In response to further questioning regarding how training will seek to ensure compliance with Article 78, particularly the restrictions on advertising or inadvertently influencing patient decisions, the Director of Health Policy drew attention to offences built into the draft law prohibiting promotion of assisted dying, explaining that these were introduced partly because other jurisdictions had experienced problematic patterns of targeted promotion to vulnerable groups, including people with disabilities. This confirms that training will need to address not only legal prohibitions but also professional behaviours that may inadvertently influence patient decisions.

Overall, the hearing demonstrated that while the Minister and his officers recognise the centrality of training within the safeguarding framework, the specific design, accreditation and delivery mechanisms remain under development. The responses confirmed the need for early

[48] Transcript – Public Review Hearing with the Minister for Health and Social Services – 19 November 2025

publication of a comprehensive training curriculum. In particular, in relation to coercion detection, capacity assessment, Article 78 compliance, and conscientious objection to aim to ensure the safe and legally compliant operation of the assisted dying service when the law comes into force.

4.2.6 Expert Adviser Findings on Training and Guidance

The Panel's expert advisers placed substantial emphasis on the central role of training and guidance in ensuring that the Draft Assisted Dying Law provides robust protection against coercion, supports accurate capacity assessment, and embeds safe safeguarding practice. Their review identifies training as a critical safeguard in its own right—one that must be sufficiently detailed, multidisciplinary and grounded in international best practice to meet the risks presented.

A major area of concern is coercion. In their analysis of the coercion-related safeguards (pp. 19–33), the advisers emphasise that coercion is inherently difficult to detect, particularly where internalised or subtle forms of influence are at play. They stress the need for training to equip practitioners with both conceptual clarity and practical tools. Their report states that training and guidance for assisted dying practitioners and all on-island health and care professionals must be developed alongside the law, and should specifically support the detection of *"the more subtle ways that coercion can occur in the assisted dying context … to help detect hidden coercion."*

The advisers further highlight that coercion in this context may intersect with domestic abuse, financial dependence and coercive control, requiring assessors to understand how vulnerability and relational dynamics may shape a patient's request for assisted dying. They note a risk that without specialised training, practitioners may overlook these complexities and thus fail to identify undue influence.

In relation to capacity, the advisers note that practitioners must be trained to apply the capacity test rigorously and consistently (pp. 40–51). Training should clarify how fluctuating capacity, acquiescence, or subtle resistance ought to be interpreted within the assisted dying process. They emphasise that capacity-related training must encompass both legal principles and practical clinical assessment skills.

The advisers make several specific recommendations for strengthening training and guidance. They recommend that the Assisted Dying Assurance and Delivery Committee be under a statutory duty to give consideration to:

i. *models of good practice for training on coercion in jurisdictions where assisted dying is permitted; and*

ii. *ii. what the Addendum sets out as matters to be included in the guidance on coercion for the assessing doctors, assisted dying practitioners and all on-island health and care professionals; and*

iii. *iii. ensuring that the indicators of coercion in the training and guidance draw attention to:*

a. the more subtle ways that coercion can occur in the assisted dying context to clarify understandings of coercion, the scope of undue influence and to help detect hidden coercion; and

b. the potential intersection between domestic abuse, financial and coercive control, and vulnerability to coercion in the context of assisted dying.[49]

They additionally identify that training must address the broader safeguarding landscape, including alignment with adult safeguarding structures, protections for people with disabilities or learning disabilities, and the role of independent advocates (pp. 33–38). The advisers argue that practitioners need explicit guidance for identifying when additional support or protective measures are required.

The report also stresses the need for comprehensive medical and procedural training, covering matters such as prognosis assessment, modes of administration, communication with patients and families, and the responsibilities of assisted dying practitioners (pp. 70–85). Adequate training is viewed as essential to consistent, ethical decision-making and to minimising the risk of error or unsafe practice within the assisted dying service.

Taken together, the expert advisers' findings reveal a clear, recurring theme: Training must be rigorous, evidence-based and sufficiently comprehensive to prepare practitioners for the complex ethical, clinical and safeguarding challenges inherent in assisted dying. They emphasise that without robust training, supported by detailed, authoritative guidance, the safeguards in the draft law will be substantially weakened, and risks relating to coercion, capacity and vulnerability will be harder to mitigate.

4.2.7 The Panel's Seventh Amendment - Training and Guidance

The Panel proposes an amendment[50] to strengthen safeguards within the Draft Assisted Dying (Jersey) Law by ensuring that training and guidance explicitly cover the identification of coercion and abuse, and by extending mandatory training beyond clinical practitioners to wider relevant agencies. The amendment makes targeted changes to Articles 62, 63, 65, and 66, adding a statutory requirement for training to include:

- How to identify risk factors associated with exposure to coercive control, domestic abuse, emotional abuse, financial abuse and other forms of undue influence
- Recognition of vulnerabilities linked to sex, sexual orientation, gender identity, age, disability and socio-economic disadvantage
- Skills for recognising whether an individual has been coerced or pressured.

These additions directly reflect the concerns raised in evidence by stakeholders, including the Royal College of Psychiatrists' emphasis on assessing internal and indirect pressure, and Dr John Stewart-Jones' warnings that coercion cannot be entirely ruled out even with training. The Panel's expert advisers also identified coercion as an area requiring further scrutiny, recommending that training incorporate best practice from other jurisdictions and cover subtle and hidden forms of undue influence.

As highlighted in the accompanying report to the Panel's Seventh Amendment, evidence from the UK, Jersey and international research demonstrates that exposure to coercive control,

[49] Expert Advisers report - Review of the Draft Assisted Dying Legislation
[50] Draft Assisted Dying (Jersey) Law 202- (P.65/2025): seventh amendment

domestic abuse, emotional abuse, financial abuse and other forms of exploitation is not evenly distributed across the population. Certain characteristics such as sex, sexual orientation, gender identity, age, disability, and socio-economic disadvantage are consistently associated with higher likelihood of abuse. Understanding these patterns, the impact of intersecting[51] identities (having more than one of these characteristics), and awareness of sub-groups at higher risk (e.g. bi women and trans people within the LGBTQ+ community are most commonly victimised), is essential for ensuring that assisted dying decisions are free from pressure or coercion. Without clear statutory requirements, training may fail to equip practitioners to recognise group-specific vulnerabilities such as economic abuse, identity-based manipulation, carer-facilitated coercion or age-related dependency. By embedding these risk factors directly into the Law, the amendment aims to ensure that training is standardised, comprehensive and inclusive, reducing the risk that practitioners overlook vulnerabilities that could impede a person's ability to communicate freely or make an autonomous assisted dying request.

The amendment also requires the Minister to ensure that this training is provided on an ongoing basis to non-clinical agencies (e.g., Jersey Domestic Abuse Support), recognising that safeguarding risks are often first identified outside clinical settings.

Overall, the amendment strengthens the draft law by:

- Enhancing the robustness of safeguarding training
- Embedding risk-factor awareness into statutory guidance
- Supporting practitioners to recognise complex, intersectional vulnerabilities
- Aligning Jersey's assisted dying framework with modern safeguarding practice and the principles approved under P.18/2024

This targeted amendment therefore provides an additional layer of protection to enable assisted dying decisions to be made freely, voluntarily, and without undue influence

4.4 Alignment with the Principles adopted in P.18/2024

The principles adopted by the States Assembly through P.18/2024 – Assisted Dying require that any legislative scheme introduced in Jersey must embed dignity, informed choice, voluntariness, safeguarding, and ethical integrity at its core. The Panel examined how far the Draft Assisted Dying (Jersey) Law 202– (P.65/2025) and its Addendum give effect to these principles specifically through the training and guidance framework.

4.4.1 Dignity and Respect for Autonomy

Where the Draft Law aligns

Statutory training and general guidance aim to equip practitioners to communicate clearly, sensitively and without bias, supporting dignified interactions and respect for the individual's values and preferences.

[51] *Intersectionality refers to a framework which is "used to understand how various forms of inequality, discrimination, and social identities (such as race, gender, class, sexuality, and disability) intersect and overlap". In the context of coercion and abuse, intersectionality can be used to recognise how overlapping identities compound an individuals vulnerability, creating heightened and distinct risks for experiencing violence and coercive control.*

The pathway requires repeated checks that decisions are voluntary and settled, and it allows individuals to pause the process to explore care and treatment options, reinforcing personal agency.

Gaps / further action needed

Administration model: Evidence indicates practitioner administration tends to become the dominant mode where both routes are offered; the Panel's findings favour a self-administration-first approach with practitioner administration reserved for physical incapacity to preserve the primacy of the person's own act and mitigate pressure to proceed.

Waiver of final confirmation: While intended to protect autonomy for those at risk of imminent capacity loss, the waiver introduces ethical and practical complexities (e.g., ambiguous gestures, fluctuating capacity, changes of mind). Clearer guidance, role clarity, and training are required so that autonomy is not compromised in practice.

4.4.2 Safeguarding and Protection from Harm

Where the Draft Law aligns

The framework mandates training (including coercion, domestic abuse, and financial exploitation), requires ongoing competency, and creates criminal offences for coercion.

Indicators of possible coercion are embedded and the pathway includes multiple decision points with the ability to halt at any sign of refusal or distress.

Gaps / further action needed

Multidisciplinary assessment: Safeguarding against "subtle, relational and hidden" coercion requires specialist input beyond medical assessment alone (safeguarding professionals, mental-capacity specialists, social care). The Panel recommends embedding this as standard practice.
Clarity of offences and appeal risks: The Panel's amendments (clarifying coercion offences and removing third-party appeals) close routes that could facilitate adversarial pressure or coercive leverage late in the process. Adoption of the Panel's amendments would strengthen alignment.

Operational guidance: Detailed, practice-ready guidance is needed on identifying and managing indirect/internal pressures (e.g., "burden" self-perception), interfacing with adult safeguarding systems, and documenting decisions consistently.

4.4.3 Freedom of Choice and Informed Decision-Making

Where the Draft Law aligns

Training and guidance on capacity assessment, voluntariness, and risk communication are designed to enable informed decisions.

The statutory right to pause, if adopted through the Minister's second amendment, for palliative/end-of-life assessment supports "real choice" by ensuring people understand alternatives and are not driven by unmet care needs.

Gaps / further action needed

Administration choice vs. safeguards: Public consultation favoured choice between modes; however, the Panel's evidence shows unconstrained choice may dilute safeguards. Clear parameters (self-administration-first; robust incapacity criteria; ongoing training) are needed to maintain informed, voluntary choice without normalising practitioner-led deaths.

Waiver practice: Further public consultation and a targeted practitioner willingness survey are required to confirm societal acceptance and workforce feasibility of acting under a waiver, and to define processes where capacity fluctuates or the person wishes to pause near the end.

4.4.4 Equality and Non-Discrimination

Where the Draft Law aligns

The ability to pause for specialist assessment, subject to adoption of the Minister's second amendment, supports equitable access to information about care options.

Gaps / further action needed

Training to identify risk factors: Training to address risk factors linked to disability, age, sex, sexual orientation, gender identity and socio-economic vulnerability, recognising unequal exposure to coercion or abuse. Adoption of the Panel's seventh amendment would achieve this and therefore strengthen alignment with P.18/2024.

Consistent specialist access: The definition of "suitably qualified health professional" in pause-and-assess provisions is broad; to avoid inequality of access, implementation guidance should guarantee palliative care expertise where clinically appropriate and set time-bound referral standards so pauses do not result in delay or distress.

Accessibility in practice: Training and guidance must operationalise inclusive communication (e.g., disability-aware practice, accessible formats) so all eligible individuals can exercise rights on an equal basis.

4.4.5 Principle of Robust Safeguards (P.18/2024)

Where the Draft Law aligns

The scheme mandates role-specific, ongoing training, integrates safeguarding throughout the pathway, provides general guidance (including for families/carers), and tasks the Assisted Dying Assurance and Delivery Committee with oversight and continuous updating.

Gaps / further action needed

Experience thresholds: The draft law does not specify minimum experience requirements for Administering Practitioners; the Panel recommends setting clear thresholds in legislation or binding guidance to support competence and public confidence.

Detailed curricula and SOPs: To translate principles into practice, the system needs published curricula and standard operating procedures covering: coercion detection (including hidden/internalised forms), capacity in complex/ fluctuating contexts, Article-78 compliance,

administration decision-making (including robust criteria for physical incapacity), and record-keeping.

Monitoring and learning: Early years of implementation should include structured monitoring (e.g., use of the pause mechanism; timeliness and outcomes of palliative referrals; waiver-related cases) to drive iterative improvements and demonstrate that safeguards function as intended.

Overall conclusion on alignment

The Panel concludes that the draft law largely aligns with the principles of P.18/2024 by embedding training, guidance, repeated voluntariness checks, and coercion offences within a regulated pathway. Full alignment, however, depends on:

(i) adopting the Panel's targeted amendments
(ii) embedding multidisciplinary assessment,
(iii) clarifying administration parameters (self-administration-first with reliable incapacity criteria),
(iv) publishing experience requirements and detailed operational guidance, and
(v) implementing robust training, monitoring and feedback to enable the framework to function safely, consistently, and ethically in practice.

4.5 International Comparators and Best Practice

The Panel's review of international evidence showed that established assisted dying jurisdictions use training as a key safeguard. Common features include:

- Mandatory initial training and accreditation
- Annual competency refreshers
- Detailed clinical guidance and assessment templates
- Specialist modules on coercion, capacity, palliative care and ethics
- National monitoring bodies to evaluate training effectiveness

The Panel notes similarities between adviser recommendations and Canadian, Dutch and Australian safeguarding practices, particularly in relation to coercion training.

4.6 Panel Observations

Across written submissions, the public hearing, expert adviser analysis, and the wider body of international and domestic evidence, the Panel consistently heard that robust, mandatory, multi-disciplinary training, underpinned by clear and detailed guidance, is essential for professionals who will assess, support or deliver assisted dying. The evidence also highlights that training must cover core areas such as decision-making capacity, ethical decision-making, communication with vulnerable groups, detection of coercion, mental health considerations, record-keeping, and adherence to Article 78's restrictions on promotional material.

Drawing together all the evidence, the Panel observes:

- Training and guidance remain insufficiently detailed in current documentation and require further development.
- Stakeholder submissions consistently call for clearer, more extensive guidance, particularly around safeguarding, coercion and professional responsibilities.
- Both the RCPsych and Dr Stewart-Jones emphasised the inherent difficulty of identifying coercion and the need for training that covers both internalised and external pressures.
- Expert adviser recommendations provide a strong blueprint for the training curriculum, particularly regarding coercion.
- The Minister confirmed that training will be developed during implementation, underscoring the need for advance publication and public transparency.
- Training must include accessibility needs highlighted in CAJ and EYECAN submissions (communication formats, sensory impairments, vulnerable groups).
- Training is integral to meeting the principles of dignity, safeguarding and freedom of choice.

The Panel makes the following key findings and recommendations.

Key Findings

KEY FINDING 25: Training is a core safeguard and must be rigorous, detailed and multidisciplinary. The evidence demonstrates that training is not merely an operational requirement but a *primary safeguard* that enables practitioners to detect coercion, assess capacity reliably, navigate ethical complexities and support vulnerable individuals. Without robust training, the protections in the draft law risk being significantly weakened.

KEY FINDING 26: The Draft Assisted Dying (Jersey) Law largely aligns with the principles of P.18/2024, however, important gaps remain in relation to safeguarding, autonomy, equality and operational robustness. Further measures and clarity, including the development of detailed training and guidance are key to full alignment with P.18/2024.

KEY FINDING 27: Coercion detection and capacity assessment require specialist skills beyond standard clinical training. Submissions and expert advice highlighted that coercion can be subtle, internalised or relational, and that certain cohorts face heightened marginalisation and vulnerability. Effective training must therefore include mental health expertise, safeguarding knowledge, and practical tools for identifying complex or hidden forms of undue influence.

KEY FINDING 28: Guidance and training remain under development and must be published early to enable preparedness. Stakeholders consistently raised concerns that guidance is not yet detailed, and the Minister for Health and Social Services confirmed that much of it will be developed during implementation. Early, comprehensive publication is essential to support safe, consistent practice in a small jurisdiction with limited clinical exposure.

KEY FINDING 29: Training must be inclusive, accessible and aligned with wider safeguarding structures. Evidence from disability and safeguarding submissions shows that communication needs vary significantly, and training must reflect the realities of assessing and supporting people with disabilities, sensory impairments, fluctuating capacity or socio-economic

vulnerability. International best practice also emphasises alignment with adult safeguarding frameworks and domestic abuse expertise.

KEY FINDING 30: Ongoing training, monitoring and evaluation are essential for system integrity and public confidence. Expert advisers and stakeholders stressed the need for continuous updating of training based on international learning, national monitoring outcomes, and emerging risks. Regular evaluation will help to ensure training remains robust, evidence-based and responsive to the evolving practice environment.

Recommendations

RECOMMENDATION 19: The Minister for Health and Social Services should ensure a time-bound publication of the statutory general guidance no later than six months before commencement of the law.

RECOMMENDATION 20: The Minister for Health and Social Services should ensure that an accredited training programme includes, but is not limited to, modules on:

i. Mental capacity assessment
j. Ethical reasoning
k. Detection of coercion and undue influence (including subtle, hidden and internalised forms)
l. Domestic abuse indicators and financial coercion (including intersectionality and awareness of sub-groups within characteristics)
m. Mental health conditions and neurodiversity
n. Communication with disabled and vulnerable individuals
o. Compliance with Article 78
p. Documentation standards and record-keeping

RECOMMENDATION 21: The Minister for Health and Social Services should ensure that training materials are co-produced with experts in disability, mental health, neurodivergence, Diversity, Equity and Inclusion (DEI), domestic abuse and palliative care.

RECOMMENDATION 22: The Minister for Health and Social Services should ensure that evidence from ongoing national and international monitoring be incorporated into training updates; and a formal evaluation framework be established to assess the effectiveness of training and guidance over time.

5 Public Awareness

5.1 Background

Public awareness has been central to the Panel's examination of the Draft Assisted Dying (Jersey) Law (P.65/2025). Ensuring that Islanders understand the legal, ethical, and practical significance of assisted dying is not only a matter of providing information - it is an important safeguard that underpins informed consent, protects vulnerable individuals, and upholds public confidence in the integrity of the assisted dying service.

The Panel examined a range of evidence on the theme of public awareness, including submissions from Citizens Advice Jersey (CAJ) and EYECAN, the expert advisers' report, and material heard during the Panel's public hearing with the Minister. This evidence demonstrated a clear consensus: public information must be factual, accessible, balanced, and inclusive, and must be delivered in a way that prevents any perception of promotion or encouragement.

5.2 Evidence Considered on Public Awareness

5.2.1 Citizens Advice Jersey (CAJ)

CAJ's submission[52] to the Panel expressed concern about the risk that certain Islanders may remain unaware of the introduction of assisted dying. They highlighted groups at particular risk of exclusion, including older Islanders, individuals in care settings, and those with sensory impairments or without internet access. CAJ wrote that some might be:

> *"in the dark on this issue, particularly the infirm that may have sight or other sensory disabilities, those residing outside of a domestic setting who may not venture outside regularly or do not access media or the internet."*

CAJ[53] advocated clear, broad messaging that emphasises awareness rather than promotion, suggesting mailshot leaflets and posters containing basic information and clear signposting to official sources:

> *"A leaflet could be created as a mailshot... explaining that the Assisted Dying Law is coming into force... [with] a contact number to gain further information... Perhaps posters could be created detailing basic information such as eligibility."*

These proposals framed public awareness as a practical matter of inclusivity and safeguarding.

5.2.2 EYECAN – Accessibility for Islanders with sight loss

A submission[54] from EYECAN reinforced and expanded upon the concerns highlighted by CAJ. EYECAN stressed that awareness levels among people with sight loss vary significantly depending on how public authorities approach engagement. They explained:

[52] Written Submission, Citizens Advice Jersey, 21 November 2025
[53] Written Submission, Citizens Advice Jersey, 21 November 2025
[54] Written Submission, EYECAN, 10 November 2025

> *"There are so many factors around awareness... access to media sources, personal interest, [and] the sentiment surrounding the subject."*

EYECAN noted that disabled and marginalised groups are not currently adequately informed, although improvements across government communications (such as audio versions of documents and disability-aware training for staff) are welcome steps. They pointed to forums such as the Visual Impairment Partnership Board as valuable and under-utilised channels for reaching those affected.[55]

Crucially, EYECAN stressed that proactive engagement is essential:

> *"Personal engagement opportunities are essential... these should be proactive efforts to engage, rather than expecting clients to find the information themselves."*

The submission also reinforced that the greatest barrier to awareness is not incapacity but assumption - the assumption that people know where or how to find information, or that they can access conventional communication formats. EYECAN urged Government to ensure availability of audio materials, plain language, and appropriately sized print formats.

This evidence has informed the Panel's conclusions regarding the design of future public awareness strategies.

5.2.3 Public Information Sessions

The Panel is aware that Government hosted information sessions across several parish halls as part of the lodging period. These sessions were open to the public and supplemented by sessions specifically designed for people with disabilities or long-term conditions, supported by Enable Jersey.[56]

These sessions were intended to be a helpful source of information for those who attended. However, as highlighted by stakeholder submissions from EYECAN and CAJ, some Islanders with disabilities require a more tailored, proactive approach to engagement. Therefore, the Panel considers that in-person sessions should form only one component of a wider public awareness requirement.

5.2.4 Themes from the Public Hearing with the Minister for Health and Social Services

During a public hearing with the Minister, questions arose regarding the boundary between legitimate public information and prohibited promotion.[57] The Panel questioned how the

[55] Written Submission, EYECAN, 10 November 2025
[56] Assisted dying in Jersey - Government of Jersey Website
[57] Transcript – Public Review Hearing with the Minister for Health and Social Services – 19 November 2025, page.30

Government intended to deliver essential information without creating the perception that assisted dying was being endorsed or presented as a preferred option.

> ***Director of Health Policy:*** *We had, as you can imagine, quite long conversations with the Law Officers and Law Drafting Officers about the phrasing of the law. What we wanted to achieve, which we are confident that we have achieved, is to allow people access to factual information about the possibility that they may have an assisted death in Jersey; that is factual information. Under the casting on the drafting of the offence to promote assisted dying, that will not capture, for example, the Jersey assisted dying service producing leaflets that they give to G.P.s that when the patient is visiting in front of the G.P., the G.P. can say: "Here you go, here is some factual information about assisted dying." That factual information, the intention would be that the assisted dying service will produce leaflets that says: "This is information about assisted dying, this is information about end-of-life care." There would always be that constant balance.*
>
> ***Deputy L.M.C. Doublet:*** *Yes, so at the same time, yes.*
>
> ***Director of Health Policy:*** *The offence is cast in such a way as to not capture the giving of factual information but the offence is cast in such a way that if, for example, a doctor was to put a big poster in a consulting room that says: "Come and talk to me about assisted dying. I am an assisted dying practitioner. I can support you in terms of ..."*
>
> ***Deputy L.M.C. Doublet:*** *That would be promotion, okay, yes.*
>
> ***Director of Health Policy:*** *That would be promotion; that is not permitted in the law. Those are the differences that we are seeking to achieve. This is a difficult area and I think that if we are all open and honest there is a possibility that when assisted dying first starts to be provided, there may be some people who are on the wrong side of that line.*
>
> ***Deputy L.M.C. Doublet:*** *Unintentionally, yes.*
>
> ***Director of Health Policy:*** *Unintentionally. Therefore, they will need to be supported to make sure they stay on the right side of that line.*[58]

The hearing reinforced concerns about materials being placed within clinical settings and informed the Panel's focus on GP surgeries as particularly sensitive environments.

5.2.5 Expert Advisers' findings on Public Awareness

The Panel's expert advisers concluded that Article 78(3) is drafted clearly and appropriately differentiates between public information and prohibited advertising. They found the provision to be "sufficiently clear" in its current form.

However, the advisers also emphasised the need for accessible, inclusive public information, recommending the use of multiple communication channels, clear signposting to palliative care services, and training for relevant professionals. They strongly encouraged a public information approach that accounts for diverse needs and abilities across the community.

The Panel notes that these conclusions align closely with the evidence from CAJ and EYECAN.

[58] Transcript – Public Review Hearing with the Minister for Health and Social Services – 19 November 2025 - Page 29

5.2.6 The Panel's Sixth Amendment - Restricting Written Information in GP Practices

Drawing on concerns raised during the review; the Panel proposes a targeted amendment[59] to the draft law. The amendment, if adopted, would restrict written information on assisted dying from being provided within GP surgeries unless a health professional is physically present with the recipient.

The Panel considers that GP practices are clinical environments in which individuals may be highly vulnerable. The placement of written information about assisted dying in such environments risks:

- Distress for patients dealing with difficult diagnoses
- Misunderstanding of eligibility or processes
- Perception that assisted dying is being promoted as a clinical service.

The Panel's amendment is deliberately narrow in scope. It does not restrict any community-based public awareness campaigns. It does not prevent GPs from discussing assisted dying with patients or providing written material during a consultation. Nor does it prevent the Government or charitable organisations from producing printed or digital information.

Its purpose is solely to seek to ensure that written information is provided in GP environments with appropriate professional support. The Panel urges the Minister for Health and Social Services to adopt this amendment as a guiding principle across all medical settings in which written information relating to the Assisted Dying Service is provided.

5.3 Alignment with the Principles Adopted in P.18/2024

The principles adopted by the States Assembly through P.18/2024 – Assisted Dying require any legislation to reflect dignity, voluntariness, informed decision-making, safeguarding, transparency and ethical integrity. The Panel therefore examined how far the Draft Assisted Dying (Jersey) Law 202– [P.65/2025] and its Addendum operationalise these principles in the context of public awareness.

5.3.1 Dignity and Respect for Persons

P.18/2024 emphasises that assisted dying must be grounded in dignity. The draft law supports this by:

- Requiring the Minister to publish general guidance (Article 63) to help Islanders understand the assisted dying process, including neutral, factual descriptions of eligibility and safeguards.
- Ensuring public information is presented in a manner consistent with dignity - Article 78 prohibits any form of promotion, preventing the trivialisation or commercialisation of assisted dying.
- Ensuring that individuals have access to information without stigma, through multi-format guidance envisaged in the Addendum, reflecting the principle that persons facing end-of-life decisions must be treated with compassion and respect.

[59] Draft Assisted Dying (Jersey) Law 202- (P.65/2025): sixth amendment

The Panel considers that these mechanisms support dignity by ensuring that information empowers individuals without steering or influencing them. In addition, the Panel considers that its proposed amendment to the draft law to restrict written information in GP surgeries unless a health professional is present strengthens this further.

5.3.2 Safeguarding and Protection from Harm

Safeguarding is central to P.18/2024. The draft law embeds safeguarding within public awareness through:

- Clear restrictions in Article 78 to prevent materials that could pressure or unduly influence vulnerable individuals.
- Guidance and training obligations (Articles 62–66) ensuring the public receives accurate, safe information and that professionals understand how to respond to concerns raised during public awareness work.
- The Addendum's requirement that information and training include sections on risk, domestic abuse, coercion and financial abuse, which seek to ensure both the public and professionals are alert to safeguarding risks.
- Public awareness activity (such as Government information sessions) helping ensure misunderstandings do not put vulnerable people at risk by clarifying strict eligibility criteria and outlining multiple layers of protection built into the process.

Together, these provisions reinforce a system where public awareness itself functions as a safeguard, reducing the risk of coercion, misinformation or inappropriate requests. The Panel is satisfied that this is in alignment with P.18/2024.

5.3.3 Freedom of Choice and Informed Decision-Making

P.18/2024 requires that individuals be fully informed of all options and able to make voluntary choices. P.65/2025 facilitates this through:

- Allowing neutral public information to be disseminated by Government so that individuals can understand the law and how to access the Assisted Dying Service if they choose.
- Requiring general guidance (Article 63) that explains the assisted dying process in clear, accessible terms, ensuring informed decision-making across the population.
- Requiring that information include signposting to other services (e.g., psychosocial and palliative care), preventing misinformation and supporting individuals to explore all options.

The Panel's public awareness analysis shows that freedom of choice requires equal access to information, especially for disabled, digitally excluded or sensory-impaired Islanders. Evidence from CAJ and EYECAN makes clear that accessible formats and multi-channel communication are essential to achieving the P.18/2024 principle of free and informed choice.

5.3.4 Ethical Integrity and Transparency

P.18/2024 calls for an assisted dying system that is ethically coherent and transparent. The draft law achieves this through:

- A well-defined distinction between information and advertising under Article 78, protecting neutrality in public communications so that information provided neither encourages or discourages people to seek assisted dying.
- Requiring the Assisted Dying Assurance and Delivery Committee to oversee training and guidance (Article 65), reinforcing ethical consistency and transparency in public messaging.
- A statutory expectation (via Addendum) that training includes the law, operational procedures, and ethical content such as recognising coercion and maintaining professional boundaries.

These mechanisms reflect P.18/2024's intention that assisted dying must operate within a strict ethical framework safeguarded by clear public communication.

5.3.5 Ensuring Equity, Accessibility and Non-Discrimination

The principles of P.18/2024 require that assisted dying (or the decision not to pursue it) be equally available to all eligible Islanders. The draft law and Addendum support this by:

- Requiring guidance suitable for a broad public audience (Article 63), enabling equitable access to information.
- Government information sessions specifically for disabled Islanders and those with long-term conditions seek to ensure inclusiveness.
- Evidence from EYECAN indicates that without accessible formats (audio, large print, plain English), equity cannot be achieved - highlighting an area where the draft law's guidance requirement must be operationalised with appropriate detail.

The Panel notes that while the draft law provides a statutory foundation, the full realisation of equality will depend on implementation and guidance design, as emphasised in the Addendum.

5.3.6 Principle of Robust Safeguards (P.18/2024) and the Public Awareness Framework

P.18/2024 requires that any assisted dying system incorporate "strict safeguards". Public awareness supports these by:

- Clarifying eligibility criteria to prevent misunderstandings;
- Ensuring individuals know about capacity assessments, voluntariness requirements and protections;
- Highlighting avenues for support when coercion or pressure is suspected;
- Providing clear, evidence-based descriptions of the process to reduce risk of misuse.

The draft law's mandatory training and guidance provisions (Articles 62–66 and Addendum) directly support the safe operation of public information by ensuring professionals can respond appropriately to public engagement.

5.3.7 Panel's Observations on Overall Alignment with P.18/2024

Taken together, the Panel considers that the public awareness framework within the draft law:

- Promotes informed choice through accessible, neutral information
- Strengthens safeguarding by ensuring information is not promotional and by requiring training on risks of coercion

- Supports dignity by respecting the emotional complexity of public communication
- Promotes equity through the obligation to publish general guidance
- Reflects ethical integrity through defined controls on information
- Implements the principles of P.18/2024 through clear statutory mechanisms.

The Panel therefore finds that the draft law substantially aligns with the principles set out in P.18/2024, while noting that real-world delivery, particularly around accessibility, will be key to fully achieving those principles.

5.4 Public Awareness Best Practice: International Comparisons

In accordance with the Panel's Terms of Reference, the Panel examined international models and best practice to determine whether Jersey's approach to public awareness aligns with, or diverges from, established assisted dying frameworks. The Expert Advisers' Report[60] provides detailed comparative insights that have been directly incorporated into this section.

While international jurisdictions vary widely in eligibility, procedural steps and institutional capacity, certain consistent themes emerge regarding the role of public awareness in safeguarding autonomy, ensuring transparency and supporting ethical practices. The advisers' analysis provides critical context for understanding where the Draft Assisted Dying (Jersey) Law P.65/2025 sits within this global landscape.

5.4.1 Public Awareness as a Safeguard: Lessons from Other Jurisdictions

The advisers noted that in many jurisdictions (including Canada, Victoria (Australia), Oregon, and parts of Europe) transparent, accessible public information on assisted dying is treated as an essential safeguard. This includes:

- Clear communication about eligibility, procedural steps and timeframes
- Accessible guidance for families, carers and the public
- A public-facing oversight body producing annual reports and educational material
- Emphasis on neutrality, avoiding any perception of encouragement

The advisers noted that Article 78(3) of Jersey's draft law, which prohibits promotional activity while permitting legitimate public information, is consistent with these international approaches and "sufficiently clear" in delineating acceptable forms of communication.[61]

The advisers highlighted that in Canada and Australia, comprehensive public information portals and community education programmes were introduced before the service became operational, ensuring the public could navigate a complex medical-legal pathway with clarity. This mirrors the expectations placed on Jersey in the Addendum, where the Government is required to publish general guidance and enable public access to neutral, factual materials.

5.4.2 International Evidence on Barriers to Awareness

The advisers emphasised that across jurisdictions, deficiencies in public awareness have been associated with:

- misunderstandings about eligibility criteria

[60] Expert Advisers report - Review of the Draft Assisted Dying Legislation
[61] Expert Advisers report - Review of the Draft Assisted Dying Legislation

- confusion over clinician roles
- lack of awareness of safeguards (such as capacity assessments and voluntariness tests)
- inequitable access to information among disabled or marginalised communities.

The Jersey evidence from CAJ and EYECAN reflects these same concerns, demonstrating that Jersey is not unique in facing challenges around disability access, digital exclusion, and the risk of vulnerable groups being uninformed. The advisers' report identifies these as critical learning points from international experience and strongly supports multi-format, inclusive communication strategies.[62]

5.4.3 Coercion and Public Awareness: The International Context

As discussed previously, the advisers' report places strong emphasis on coercion and undue influence, noting that in several long-standing assisted dying jurisdictions, safeguarding failures often stem not from procedural oversights but from invisible pressures that are difficult to detect without proper training and clear public guidance. They emphasise:

- Coercion can be "subtle, relational and hidden"
- Public information must make clear the protections available
- Guidance must explain the difference between support and influence
- Practitioners must be trained to identify and respond to disclosure or suspicion

The advisers' recommended amendments (p.14, p.30) explicitly draw on international models of best practice in coercion detection and suggest that Jersey's framework incorporate these lessons through both training and public communication.

The Panel notes that effective public awareness reduces the burden on healthcare professionals by ensuring that individuals understand the types of influence that may compromise voluntariness. This reflects international practice where public campaigns frequently highlight the meaning of voluntariness and the role of safeguarding bodies.

5.4.4 Accessibility and Equity: International Benchmarks

International experience demonstrates that failing to provide accessible, inclusive public information tends to result in inequitable uptake or misunderstanding of the law. The advisers' report notes that jurisdictions such as Victoria and several Canadian provinces have produced extensive accessible materials (including audio, Easy Read, plain language guidance, and translated documents) to enable equity.

In Jersey, evidence from EYECAN[63] and CAJ[64] highlighted that individuals with sight loss, sensory impairments and digital exclusion are at risk of missing essential information unless formats are adapted. The advisers' analysis confirms these concerns and supports international practice in which accessible formats are not optional but integral to public awareness and safeguarding.

5.4.5 The Panel's Ninth Amendment – Presentation of the Annual Report to the States Assembly

[62] Expert Advisers report - Review of the Draft Assisted Dying Legislation
[63] Written Submission, EYECAN, 10 November 2025
[64] Written Submission, Citizens Advice Jersey, 21 November 2025

The advisers highlighted that most international jurisdictions maintain:

- annual reporting
- data publication
- publicly accessible oversight body websites
- clear communication pathways for the public

These contribute to public reassurance, transparency and informed discourse.

Article 74 of P.65/2025 requires the Assisted Dying Assurance and Delivery Committee to report on demographic and service-level information annually, a mechanism consistent with international expectations that public awareness is supported by transparent reporting, enabling citizens to see how the system is functioning.

The Panel proposes an amendment[65] to further strengthen oversight by placing a requirement for the Annual Report to be officially presented to the States Assembly by the Minister for Health and Social Services. Despite its important role, the draft law does not explicitly require the States Assembly to formally receive the Committee's findings. The Panel is concerned that this could lead to inconsistent reporting and weaken parliamentary oversight of an area that is ethically sensitive and subject to high public interest. The Panel considers this requirement to be an essential component of effective governance and believes that reporting of this nature should be embedded within the legislation rather than left to administrative practice.

The advisers' emphasis on the importance of monitoring, including demographic risk factors, mirrors international practice where demographic data is used to identify inequities in communication and access.

5.4.6 The Panel's Eighth Amendment - Reviewing the Law's Implementation and Ensuring Disability Representation

The Panel proposes an amendment[66] introducing two new Articles (Article 77 and Article 78) to strengthen transparency, accountability, and inclusivity in how the assisted dying framework is implemented and evaluated. Together, these provisions require (i) an early statutory review of the operation of the Law, and (ii) structured involvement of disability representatives during both implementation and review.
The amendment inserts a new Article 77, requiring the Assisted Dying Delegation and Assurance Committee to carry out and publish a review of how the Law is operating within three years of its full commencement. This measure aims to ensure that Jersey's assisted dying framework is subject to timely scrutiny once real-world practice is established. The Panel considers this essential for:

- Testing safety and proportionality early, identifying any emerging risks, gaps, or unintended consequences before becoming entrenched.
- Providing transparency for Islanders through a publicly available account of how the Law is functioning in practice.
- Embedding continuous improvement, enabling the updating of guidance, training, and safeguards.

[65] Draft Assisted Dying (Jersey) Law 202- (P.65/2025): nineth amendment
[66] Draft Assisted Dying (Jersey) Law 202- (P.65/2025): eighth amendment

- Ensuring accountability, avoiding open-ended review timetables by placing a clear statutory duty and deadline on the Committee.

This timely review mechanism supports a responsive, evidence-led approach to an ethically sensitive area of public policy.

The amendment also inserts Article 78, which requires the Committee to consult "appropriate representatives" of people with disabilities:

- when carrying out its main implementation role under Article 57(1); and
- when conducting and publishing the statutory review under Article 77.

This consultation duty embeds the lived experience of disabled Islanders directly into the governance and oversight of the assisted dying framework. The Article defines "appropriate representatives" flexibly, allowing engagement with the most relevant groups as they evolve. The Panel envisages organisations such as Enable Jersey, Autism Jersey, ADHD Jersey, Liberate, EYECAN, AllMatters Neurodiverse Jersey and others being involved, depending on the issue at hand.

The Panel's approach is informed by expert advice referencing the UN Convention on the Rights of Persons with Disabilities (UNCRPD), which emphasises equal recognition before the law and access to supports needed to exercise legal capacity. The advisers noted that any capacity-related mechanisms must respect the person's will and preferences, be proportionate, and avoid undue influence or conflicts of interest.

Consulting disability representatives enables:

- Guidance and operational processes to reflect the breadth of disability, including sensory, cognitive, learning, physical, neurodivergent, fluctuating, and hidden disabilities.
- Accessible communication, including formats such as large print, audio, Braille, Easy Read, BSL/ISL interpretation, and accessible venues, is embedded from the outset.
- Reasonable adjustments are developed through lived-experience insight, strengthening fairness and usability.
- Safeguards relating to consent, capacity, and undue influence are informed by real-world understandings of how disabled people may experience vulnerability or pressure.
- Monitoring and review processes capture disability-relevant data and identify any barriers or inequalities in practice.

A written submission from EYECAN, for example, highlighted the importance of proactively addressing accessibility and avoiding assumptions that exclude people with visual impairments from meaningful engagement.

The Panel's expert advisers recommended either establishing a dedicated Disability Advisory Board or embedding disability representation directly into implementation and review. The Panel chose the latter, reflected in Article 78, as the option best suited to Jersey's scale and governance structure. They further advised that pairing such a requirement with a timely statutory review would enable disability perspectives to be structurally integrated into evidence-gathering, evaluation and improvement.

5.5 Panel's Observations

Drawing on the Expert Advisers' Interim Report, the Panel concludes that Jersey's approach to public awareness through Article 78, general guidance obligations, public information sessions, and the emerging training framework, aligns strongly with international models, particularly in:

- maintaining strict neutrality in public communications
- emphasising safeguarding and coercion awareness
- ensuring transparency through statutory reporting
- acknowledging the need for accessible multi-format information
- creating a centralised Assisted Dying Service responsible for oversight and guidance.

However, the advisers' international analysis also highlights areas requiring ongoing attention:

- ensuring accessibility standards are rigorously applied
- ensuring guidance is published early and updated regularly
- ensuring public information clearly situates assisted dying among the full range of end-of-life care options
- ensuring clear, proactive communication to groups at higher risk of coercion or exclusion.

The Panel concludes that with these considerations implemented, Jersey's public awareness framework is consistent with the principles of P.18/2024 and aligned with international best practice as interpreted by the expert advisers.

In consideration of all the evidence, the Panel notes that public awareness is essential to safe and ethical implementation of assisted dying. However, significant barriers exist for certain groups, particularly disabled Islanders and those with sensory impairments.

The Panel considers that public information must be factual, accessible, and sensitive to diverse beliefs. Furthermore, that GP practices should require an additional safeguard for the distribution of written information. The Panel's amendment supports a proportionate approach to this that strengthens safeguards without unduly restricting public awareness.

The Panel makes the following key findings and recommendations.

Key Findings

KEY FINDING 31: Public awareness is a core safeguard and must reach all Islanders, including those most marginalised and at risk of exclusion. Stakeholder evidence shows that many Islanders, particularly disabled people, older adults, care-home residents and those without digital access, may otherwise remain unaware of the law's introduction.

KEY FINDING 32: Accessible, inclusive, multi-format, proactive communication is essential to informed choice and equity. Stakeholders and expert advisers emphasised that equitable access requires audio, large print, plain-language materials, Easy Read formats, and alternative routes beyond digital channels. Without these, key groups will be unable to make informed decisions or understand safeguards.

KEY FINDING 33: The draft law's boundary between factual information and prohibited promotion (Article 78) is clear but operationally sensitive. Evidence from the public hearing

demonstrated that providers will need support to comply with restrictions on promotional content, especially in clinical settings such as GP practices. This underpinned the Panel's amendment restricting unsupervised written material in GP practices.

KEY FINDING 34: The Panel's analysis shows that, in terms of public awareness, the draft law substantially aligns with the principles set out in P.18/2024 while noting, however, that practical implementation, particularly around accessibility, will be key to fully achieving those principles.

KEY FINDING 35: Jersey's approach to public awareness aligns broadly with international best practice, but successful implementation depends on early guidance, strong accessibility standards and targeted outreach. Expert advisers noted that Jersey's model is consistent with international norms on neutrality, transparency and safeguarding, but warned that real-world delivery (particularly accessible formats, timely publication of guidance, and sensitive engagement with disabled Islanders) will determine whether the framework fully meets best-practice standards.

Recommendations

RECOMMENDATION 23: The Minister for Health and Social Services should ensure that an "Accessibility Annex" is attached to the guidance, specifying audio, large-print, Easy Read/plain language, and non-digital distribution routes for inclusion and accessibility purposes.

RECOMMENDATION 24: The Minister for Health and Social Services should ensure that in public materials, neutral signposting is included on what to do if someone feels pressured, and a plain explanation of the law's voluntariness/capacity checks.

RECOMMENDATION 25: If the Panel's sixth amendment is adopted, the Minister for Health and Social Services should include in guidance that written materials are provided in GP practices only in the presence of a health professional, as well as best practice guidance on what this should look like from an operational perspective.

RECOMMENDATION 26: The Minister for Health and Social Services should, alongside the statutory annual report, publish a plain-English summary (reach, accessibility uptake, key learnings) to support transparency and continuous improvement.

RECOMMENDATION 27: The Minister for Health and Social Services should collect robust and appropriate data and evidence during the initial review to demonstrate a clear understanding of the public's awareness of the service. In doing so, the Minister should make every reasonable effort to engage and gather insights from marginalised groups across the island to ensure that all community perspectives are represented.

RECOMMENDATION 28: The Minister for Health and Social Services should incorporate the Panel's sixth amendment concerning written information provided to general practitioners about the assisted dying service as a guiding principle for all settings in which information on assisted dying will be delivered. This principle should be explicitly embedded within the guidance developed to support the implementation and operation of the service, ensuring consistency, clarity, and accessibility across all healthcare and community environments.

6 Conclusion

The Assisted Dying Review Panel undertook this review recognising both the profound ethical weight of assisted dying and the responsibility placed on the States Assembly to support the introduction of a legal framework in Jersey that is as safe as possible, robust, and aligned with the principles adopted in P.18/2024. Throughout the review, the Panel received extensive evidence from stakeholders, expert advisers, healthcare organisations, charities, and members of the public. It examined international models, considered operational implications for a small jurisdiction, and tested the Draft Assisted Dying (Jersey) Law against the principles of dignity, informed choice, voluntariness, safeguarding, equality, and ethical integrity.

The Panel acknowledges the significant work undertaken by the Government to develop the draft legislation and welcomes the safeguards already embedded within the draft law, including statutory training, repeated checks on voluntariness, the ability for individuals to pause the process, and criminal offences for coercion and prohibited promotion. These measures demonstrate clear intent to uphold the principles of P.18/2024 and to create a regulated assisted dying framework underpinned by careful oversight.

However, the Panel's analysis also identifies areas where key safeguards remain under-developed or insufficiently defined, and where further action is necessary to provide an assisted dying service that meets the standard expected by the Assembly. Across multiple chapters of this report, common themes emerged:

- Coercion is subtle and multifaceted, requiring multidisciplinary assessment rather than medical evaluation alone.
- Decision-making capacity in the assisted dying context requires enhanced safeguards, and the proposed waiver of future capacity raises complex ethical and practical risks not yet fully addressed.
- Administration pathways must prioritise safety, and international evidence supports a self-administration-first model to reduce reliance on practitioner involvement.
- Training and guidance require significant further development, particularly in relation to coercion detection, capacity assessment, vulnerable cohorts, Article 78 compliance, and operational consistency.
- The financial model remains indicative, with structural gaps, untested assumptions, and uncertainty about long-term sustainability in a pressured health system.
- Public awareness must be accessible, proactive and inclusive, with clear guardrails to prevent inadvertent promotion and aim to ensure that vulnerable Islanders are not left behind.
- Palliative and end-of-life care must remain central, ensuring that assisted dying is never perceived as a substitute for high-quality care.

Taken together, the Panel concludes that the Draft Assisted Dying (Jersey) Law 202– largely aligns with the principles set out in P.18/2024, but full alignment is contingent on the adoption of key amendments and the development of detailed, meaningful, authoritative guidance and training. Critical safeguards, particularly in relation to coercion, practitioner experience,

administration routes, capacity assessments, and the waiver, require further refinement to ensure they function effectively in practice.

The Panel therefore presents a comprehensive package of recommendations aimed at strengthening the draft law, improving operational clarity, and ensuring that the assisted dying framework is proportionate, safe, and ethically grounded. These recommendations seek to provide practical steps to uphold the Assembly's stated principles and promote trust in the integrity, fairness, and safety of any future assisted dying service.

In closing, the Panel recognises the sensitivity of this subject and the diversity of views held across the community. Assisted dying legislation must be built on a foundation of trust, transparency, and strong safeguard structures. Implementation will demand careful leadership, sustained engagement with professionals and the public, and a commitment to monitoring and continuous improvement. With the appropriate amendments and guidance in place, Jersey has the opportunity to establish a framework that is compassionate, rigorous, and reflective of the values set out by the Assembly.

Appendix 1

Panel Membership

Deputy Louise Doublet (Chair)

Deputy Catherine Curtis (Vice-Chair)

Deputy Sir Philip Bailhache (Member)

Terms of Reference

1. To conduct a comprehensive review of the proposed Assisted Dying legislation, with consideration to the following:

    a. Evaluating the proposal's legal, medical, financial and sustainability implications
    b. Evaluate any further arising ethical considerations
    c. Assessing its alignment with the principles of dignity, safeguarding and freedom of choice
    d. Evaluating the adequacy of the proposed safeguards for all individuals involved in the proposed service.

2. To determine whether the legislation gives effect to the principles set out by the States Assembly through the adoption of P.18/2024 – Assisted Dying, as amended.

3. Taking into consideration the existing body of evidence previously received to examine and compare international models and best practice in relation to the legislation.

Evidence Considered

Public Hearings

Transcript – Minister for Health and Social Services – 19 November 2025

Written Submissions

A total of 13 written submissions were received by the Panel:

- British Medical Association: Written-Submission-British-Medical-Association-23rd-July-2026.pdf
- General Medical Council: Written-Submission-General-Medical-Council-27th-August-2026.pdf
- Jersey Care Commission: 20251104-Jersey-Care-Commission-Response.pdf
- General Pharmaceutical Council: Assisted Dying Review Panel – call for evidence
- Royal College of Psychiatrists: RCPsych-evidence-submission-to-the-Assisted-Dying-Review-Panel_Jersey_November-2025.pdf
- EYECAN: 2025-11-10-Submisison-EYECAN.pdf
- Citizens Advice Bureau: 2025-11-21-Submission-CAB.pdf
- Finance Representative: Written-Submission-Anonymous-1.pdf
- Jersey Dying Well Group: 2025-11-07-Submission-Dr-John-Stewart-Jones.pdf
- Baroness Finlay of Llandaf: 2025-12-10-Baroness-Finlay-of-Llandaff.pdf
- David Siouville: Written-Submission-David-Souville-4th-September-2025-1.pdf
- Jeannine Hochet: Written-Submission-Jeannine-Hochet-4-September-2026.pdf
- Mark Leeman: Written-Submission-Mark-Leeman-6-October-2025.pdf

Other Evidence Considered

- Assisted Dying in Jersey - Ethical Review: The Ethical Review is an evidence-based report, commissioned by the Government, and produced by three ethicists about the final proposals for assisted dying in Jersey in November 2023.
- S.R.1/2026 – Interim Report – Review of Assisted Dying Legislation – 14 January 2026 (Expert Advisers' Report)
- S.R.3/2024 – Assisted Dying Review Panel – 14th May 2024
- S.R.3/2025: Response – Response of the Minister for Health and Social Services – Review of Assisted Dying – 17th May 2024
- Jersey Assisted Dying Citizen's Jury
- States of Jersey Assisted Dying Proposal – P.95/2021
- Draft Assisted Dying (Jersey) Law 202- (P.65/2025)
- Draft Assisted Dying (Jersey) Law 202- (P.65/2025): Addendum
- End-of-Life Care (P.73/2025)
- States of Jersey Assisted Dying (P.95/2021): Amendment
- Public engagement summary report on assisted dying in Jersey
- Assisted Dying in Jersey Phase 2 Consultation Feedback Report
- Assisted dying in Jersey overview (gov.je)
- States Assembly | Transcript - Review of Assisted Dying Review Hearing - Minister for Health and Social Services - 3 A
- Quarterly Hearing Transcript - Health and Social Security Scrutiny Panel - 20 May 2025
- Public Hearing Transcript - Health and Social Security Panel - 15 October 2025
- Draft Assisted Dying (Jersey) Law 202- (P.65/2025): second amendment

Review Costs

The Review Panel had received approval from the Scrutiny Liaison Committee to receive up to £65,900 for the Review. The costs of this review totalled £10,084.46 for consultant fees, advertising and public hearing transcription costs.