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Assisted Dying Review Panel

Review of Assisted Dying

Witness: The Minister for Health and Social Services

Wednesday, 19th November 2025

Panel:

Deputy L.M.C. Doublet of St. Saviour (Chair)

Deputy C.D. Curtis of St. Helier Central (Vice-Chair)

Deputy P.M. Bailhache of St. Clement

Professor S. Ost

Dr. A. Mullock

Professor N. Preston

Witnesses:

Deputy T. Binet of St. Saviour, The Minister for Health and Social Services

Dr. J. Grose, Chair, End-of-Life Partnership Group

Ms. R. Johnson, Director of Health Policy

Ms. A. Hamon, Policy Principal

Ms. J. Poynter, Associate Director, Improvement and Innovation

[12:03]

Deputy L.M.C. Doublet of St. Saviour (Chair):

Good afternoon, everybody. We are the Assisted Dying Review Panel and this is a review hearing with the Minister for Health and Social Services. My name is Deputy Louise Doublet, I am the chair of the panel. I will let my panel and advisers introduce themselves.

Deputy C.D. Curtis of St. Helier Central (Vice-Chair):

I am Deputy Catherine Curtis, the vice-chair of the panel.

Deputy P.M. Bailhache of St. Clement:
Deputy Philip Bailhache, member of the panel.

Deputy L.M.C. Doublet:
Our advisers online, if you could introduce yourselves, please.

Professor S. Ost:
I am Professor Suzanne Ost. I am from the School of Law at Lancaster University. Nice to meet you.

Dr. A. Mullock:
I am Dr. Alex Mullock. I am from the University of Manchester, again in the Law School.

Professor N. Preston:
Hello, I am Nancy Preston. I am Professor of Supportive and Palliative Care from Lancaster University.

Deputy L.M.C. Doublet:
Thank you very much for joining us. We do not usually have advisers at our hearings but our advisers have agreed to join us today. It will mostly be the panel asking questions but the advisers may ask one or 2 supplementaries on areas of the finer detail, which we have just spoken about before. Minister, thank you for joining us today. If you could introduce yourself and your team, please.

The Minister for Health and Social Services:
Okay. Deputy Tom Binet, Minister for Health and Social Services. I think we will start at the end and go around this way.

Chair, End-of-Life Partnership Group:
Afternoon, everyone. My name is Dr. James Grose. I am a Palliative Medicine Consultant here in Jersey and I chair the operational group for assisted dying, as well as chairing the End-of-Life Care Partnership Group. Pleased to meet you.

Director of Health Policy:
Ruth Johnson, Director of Health Policy for the Government of Jersey.

Policy Principal:

Anna Hamon, Policy Principal for the Government of Jersey.

Associate Director, Improvement and Innovation:
I am Jo Poynter, the Associate Director for Improvement and Innovation, including commissioning.

Deputy L.M.C. Doublet:
Thank you. I believe we are waiting for some nameplates, so they will be popping in very shortly. The hearing is being filmed and streamed live and a recording will be made available. We were hoping to have some attendees today but I think the weather has put people off. I am hoping that there will be some people viewing online. Okay. We have 2 hours for the hearing. We may stop for a comfort break but hopefully we will just be able to carry on and get through the questions that we have. We do have quite a lot of questions and if answers could be succinct and focus on new details where possible, please. Minister, some opening questions for you. Can you explain whether consideration has been given to providing greater clarity in the legislation around how unbearable suffering is assessed in order to promote consistency and robustness in patient support?

The Minister for Health and Social Services:
I think, as I mentioned outside, there is a number of detailed questions here and the quality of the responses would be much better if I refer those questions directly to either Ruth or to Anna.

Deputy L.M.C. Doublet:
Okay, yes. If you can always try where you can to answer as much as you can, then we are happy for you to pass on.

The Minister for Health and Social Services:
I certainly will but, as I say, there is a colossal amount of detail here. As I say, the quality of the response will be better from one of the officers.

Director of Health Policy:
Yes, we did give consideration as to whether or not on the face of the law we should provide more detail as to what, firstly, the definition of unbearable suffering was and also detail as to how unbearable suffering is assessed. It is the case that no other legislation that permits assisted dying, which references unbearable suffering, seeks to define it. That is because unbearable suffering, by its definition, is subjective. Our law is very clear about the subjective nature of unbearable suffering. What we have done, because we are very cognisant of the concerns around the subjectivity of unbearable suffering, is in the version of the law that is lodged we have introduced a new provision that requires assessing doctors by law to challenge the person if the assessing doctor believes that that person's assessment of their likelihood be able to bear pain or bear the treatment is incorrect.

We have hardwired into the law a check and challenge process. As you know, there will be detailed assessment guidance and that assessment guidance will deal with how unbearable suffering is assessed and determined and discussed on a day-to-day basis.

Deputy L.M.C. Doublet:
Okay, that is helpful. Thank you. My next question was going to be, Minister, you will be aware of the submission from the Jersey Care Commission.

The Minister for Health and Social Services:
Indeed, yes.

Deputy L.M.C. Doublet:
They suggested that the clear guidance should ideally be provided. Am I to understand that that is something that will come after the legislation and will be within the guidance and that would be covered?

The Minister for Health and Social Services:
There has been additional work in that part …

Director of Health Policy:
Yes, that will be in the guidance.

Deputy L.M.C. Doublet:
Okay, thank you. Also, the Jersey Care Commission welcomed the proposal to embed the safeguards in primary legislation and noted that this approach helps to ensure that any future amendments to the law would require a full legislative process. Minister, this is the kind of slippery-slope argument that has been raised, has it not, by some critics of the legislation? Could you just explain to us how you have ensured that the draft law is designed to protect against any unintended broadening of the legislation over time?

The Minister for Health and Social Services:
I think just by virtue of the fact that this is comprehensive as it is and any amendments will require the full legal process to be gone through. I think, as far as I can see, it is as safeguarded as it possibly can be, but I would invite either of the 2 ladies to add anything further that they think might …

Deputy L.M.C. Doublet:
I think that is okay for now, thank you.

The Minister for Health and Social Services:
Is that okay, is it?

Deputy L.M.C. Doublet:
Yes. You agree that enshrining the safeguards in the primary legislation is an effective way to guard against any incremental expansion. In terms of future Assemblies and if there were any proposals to expand the criteria or the scope of assisted dying, what mechanisms are in place to ensure that there would be a full public consultation and indeed Ministerial oversight that it could not just be easily amended, that there would be full scrutiny and oversight of any future changes?

The Minister for Health and Social Services:
I can only give you a basic answer to that insofar as we live in a democracy and I cannot really account for what any future Assembly may or might not choose to do or the manner in which they may choose to approach things. As we all know, if there was a move to turn this law on its head for a future Assembly, that would be a process that is open to them. I think there is a limit to what we can do to find what may happen in future Assemblies.

Deputy L.M.C. Doublet:
Yes, we cannot compel future Assemblies but in terms of recommendations - and of course we would make some recommendations in our report - do you feel that it is worth recommending that future Assemblies should have that additional detailed in-principle debate, which was of course an extra step that you yourself brought for this stage? Do you think that should happen with any future changes?

The Minister for Health and Social Services:
We can make that recommendation. I do not know if that is included anywhere in the draft. Is there any recommendation to the effect?

Deputy L.M.C. Doublet:
It is your opinion that I am after at the moment.

The Minister for Health and Social Services:
An opinion. To my mind I think that things are sufficiently robust, that would be my own opinion but there may be differences of view.

Deputy L.M.C. Doublet:
You think that that step is wise.

The Minister for Health and Social Services:
It can be, yes.

Deputy L.M.C. Doublet:
Okay, thank you. During previous debates - and of course we had 2, did we not, because we had the first in-principle debate and then the second much more detailed in-principle debate - there were concerns raised by Members and campaigners about the legislation. Could you outline briefly how you have made sure that those concerns have been covered in the legislation and in terms of reassuring people?

The Minister for Health and Social Services:
I think the process itself, the comprehensive nature of the process speaks for itself. There were a number of concerns raised and I am not aware of any specific concern that has been raised that has not been attended to. I think, as I say, that speaks for itself. In my view, if anybody can highlight anything that has not been addressed I am sure we would be prepared to address it. It is my understanding that every major concern, every real concern has been addressed.

Deputy L.M.C. Doublet:
Okay, thank you. I will give one example then. There were some concerns raised by Islanders with disabilities and the worry there is around coercion or perceived pressure to opt for assisted dying. How are Islanders with disabilities protected by this legislation?

The Minister for Health and Social Services:
I will ask Ruth to provide a bit of detail but I do remember seeing some of the consultation responses and there were some disabled people who felt quite annoyed that other people were speaking on their behalf and that as disabled people they were not to be boxed off and told that they are a special case. They wanted the right to assisted dying if they so wished. I can understand some of the concerns but I think we have to respect the rights of disabled people to be treated as individuals rather than be corralled into, if you like, a batch of people that need someone else to patronise or protect them.

Deputy L.M.C. Doublet:
Yes, I agree with that but, yes, please do provide detail.

Director of Health Policy:
The law has safeguards hardwired into it, which are there to support and protect all people, including people with disabilities. Those safeguards relate to the fact that the assessing doctors have to be

satisfied as to the fact that the wish that is being made is a voluntary wish, i.e. it is not subject to coercion. That has to be checked at all steps within the process. In addition to that, there is training requirement for mandatory training and, as set out in the additional information that has been provided in an addendum to the report, a lot of that mandatory training will focus on coercion and identification of coercion. In response to some of the concerns that were raised, we also developed some additional proposals which were adopted by the States Assembly, which was for the creation of multidisciplinary teams. Multidisciplinary teams are really important because they include different professionals with different skill sets, such as social workers who have a professional experience very often in identifying coercion. We have hardwired protections and safeguards throughout the whole of the law to protect all people, including those with disabilities.

[12:15]

The other thing to say is within the offences of the law obviously there are offences relating to coercion with very severe penalties but there are also offences that are in the law that relate to the promotion of assisted dying. Those offences have been built in because we recognise it in some other jurisdictions there has been concerns about the active promotion of assisted dying to certain cohorts of people, including people with disabilities. We built in offences to protect against those sorts of behaviours.

Deputy L.M.C. Doublet:
Okay, thank you, that is really clear. We have got some questions that relate to that a bit later on, but I will move on to the submission from the General Medical Council and the British Medical Association and concerns raised in those submissions. Can you confirm whether the law has addressed those concerns, in particular, Minister, the wording around: “Awareness of a person’s state of mind” and specifically the phrase “as known at the time.”? Has that been incorporated into the legislation?

The Minister for Health and Social Services:
My understanding is that there are still negotiations going on to fine-tune those responses. We discussed this in the briefing session before. I think you have probably got an update as to where we are and the latest with that.

Director of Health Policy:
Yes, certainly. Obviously, as you would imagine, we have been through those submissions in detail. Some of the concerns, the submissions that were provided to you were on an earlier draft of the law, not on the draft of the law as lodged. After we had provided that earlier draft, Anna had active conversations with those regulatory bodies that had raised with us the concerns that they are putting

in the submissions. We have made amendments to the law as drafted, which we believe deal with those. Since the submissions to yourselves have been published, what Anna has gone back to them to say: "You have said this, this is what we have done in the draft law. Are you satisfied and comfortable that we have fully addressed in the draft law the concerns you have raised?" Also, we have had a discussion with the Minister. In the event they come back and say: "We think that the law would benefit from clarification", the Minister is very open to making any amending clarifications that may be required.

Deputy L.M.C. Doublet:
Okay, that is really helpful, thank you. What would also be helpful to the panel is to perhaps have sight of some of that correspondence if their permission is given by those bodies, so that we can understand their views and obviously prevent duplication of correspondence. That would be helpful.

Director of Health Policy:
Yes, absolutely.

Deputy L.M.C. Doublet:
Thank you. Our officers will be in touch to arrange that. Okay. I think I have one more before I move on to my vice-chair. Minister, there is a specific model of assisted dying that you are proposing with the draft legislation. Could you just explain for us the difference between assisted suicide and euthanasia and how that is relevant to the legislation?

The Minister for Health and Social Services:
I am not sure that I can completely answer that. The difference between euthanasia and assisted dying, my understanding, and forgive me as a layperson, I thought …

Deputy P.M. Bailhache:
Assisted suicide and euthanasia.

The Minister for Health and Social Services:
Assisted suicide …

Deputy L.M.C. Doublet:
Happy for officers to …

The Minister for Health and Social Services:
Yes, that is too technical. Yes, Anna, would you be happy to attempt that one?

Policy Principal:

I think it sets out there is no universally-agreed definitions of either. What our law does is it allows for both of those. If we are talking about assisted suicide, as in the sense of physician-assisted suicide, that is about an administering practitioner supporting a person to self-administer approved drugs which would end their life. If we are talking about euthanasia, under the Jersey draft law then we are talking about the administering practitioner administering those drugs to end a person's life. The draft law does not use the terminology of euthanasia but it has that effect and it covers both, as agreed by the P.18 proposals that both modes for an assisted death are permissible and it would be for the individual to decide.

Deputy L.M.C. Doublet:

Thank you. Okay, that is really helpful. The reason we ask is that sometimes in submissions people are using that terminology, so I wanted to get to that shared understanding of how it applied to our …

The Minister for Health and Social Services:

I had not spotted the word euthanasia anywhere in the legislation, so I was slightly confused without having a legal definition of what euthanasia is to provide you with a …

Deputy L.M.C. Doublet:

Yes, but when the panel are reading submissions and background information that term is often used. It helps us to establish how it applies to the legislation. Minister, have you weighed up the ethical distinctions between assisted suicide and euthanasia when you considered the shaping of this legislation?

The Minister for Health and Social Services:

Not in those clinical terms, no, I have not. I have got to answer the questions as I see fit; that is a slightly confusing question for me. I have gone through all of this all the way through the process and I am very comfortable with it. I do not quite know what you are trying to maybe say.

Deputy L.M.C. Doublet:

I wonder if the officers recall a time when you considered the ethical implications of these.

Director of Health Policy:

Yes, so …

The Minister for Health and Social Services:

Hang on a second, ethical implications, I think that is an assessment that I make throughout the whole process. The whole thing has to be ethically assessed at every stage, which I am very, very comfortable to say that I have done. As I say, sometimes the nature of the questions are slightly difficult to answer in the way that you ask them, for me and perhaps that is because I am not as …

Deputy P.M. Bailhache:
May I?

Deputy L.M.C. Doublet:
Okay. Go on, yes.

Deputy P.M. Bailhache:
What we are suggesting is that there is a material distinction between a person who takes his or her own life of his or her own volition and a medical practitioner or a nurse injecting someone to bring life to an end. There is a material distinction between the 2; would you accept that?

The Minister for Health and Social Services:
Yes, absolutely, yes. Articulated in that form, that makes much more sense to me, yes.

Deputy P.M. Bailhache:
Thank you.

Deputy L.M.C. Doublet:
Okay. If you could just comment on your views on the difference between those 2 things and …

The Minister for Health and Social Services:
First, that I do understand that distinction and, secondly, on a personal basis I hope that suggests that is what you are asking me, that I am personally comfortable with both.

Deputy L.M.C. Doublet:
Okay, can you explain why it was important that you drafted the law in such a way that included both of those?

The Minister for Health and Social Services:
My understanding from all of the consultation that has been done is that that is what is going to be acceptable to everybody but I take it as read that that is already understood.

Deputy L.M.C. Doublet:

Okay.

The Minister for Health and Social Services:
Forgive me if I have not quite understood what you are angling at but the way you articulated it, Deputy Bailhache, makes perfect sense to me.

Deputy P.M. Bailhache:
I think we are putting to you that there is this material distinction.

The Minister for Health and Social Services:
There is.

Deputy P.M. Bailhache:
One of the question is whether this distinction was discussed with healthcare professionals so as to give them the opportunity of considering whether the law should be restricted, as it would be in the United Kingdom or in England, for example, and in other places, to what is assisted suicide rather than euthanasia.

The Minister for Health and Social Services:
I fully understand that distinction now, yes, but as I understand it, the consultation has been endless and that has been part and parcel of that consultation process.

Director of Health Policy:
Yes. I wonder if I may be able to help with some specifics. From the very start of the work that we have been doing on assisted dying - which, as you know, we have been working on for about 5 years now - we were from a policy perspective very clear about the differences between euthanasia and assisted suicide. We have built into the public consultations, and to the professional consultations we did, those distinctions. We asked people about those 2 different modes of assisted dying, for want of a better description. We know that there are some healthcare professionals, as there are some members of the public, who support assisted suicide but do not support euthanasia. Our law provides for both of those. Our law recognises those distinctions. What it very importantly does is it provides safeguards for professionals who support assisted suicide but do not support euthanasia. Administering practitioners, the people who in our law are there at the point at which the approved drug is provided to the person, can opt to only support self-administration to the person, i.e. to support assisted suicide, or they can agree to support euthanasia. We have left it to the ability of healthcare professionals to determine what their level of participation is. We have provided them the right in law to conscientiously object to euthanasia and associated employment

protections where they do. We have hardwired that difference of view about individual healthcare providers' view about the acceptability of those 2 different modes of assisted dying into our law.

Deputy P.M. Bailhache:
It is not hardwired in the law, is it?

Director of Health Policy:
The law provides that an assisted death can be through self-administration or practitioner-administered. The law allows for that. The law then says the individual can determine which of those 2 modes that they want and the administrating practitioner can determine which of those 2 modes that they personally will participate in.

Deputy P.M. Bailhache:
That was the point that I was making; is that in the law?

Director of Health Policy:
Yes, it is in the law. Yes it is in the law, yes, yes.

Deputy C.D. Curtis:
Professor Ost would like to ask a question.

Deputy L.M.C. Doublet:
Yes, please.

Professor S. Ost:
Thank you. My question to the Minister is, was it considered limiting the availability of practitioner-administered assisted dying to those cases where the person, the patient, is physically unable to self-administer the approved drugs?

The Minister for Health and Social Services:
Was that considered?

Policy Principal:
It was, but it was before you were Minister. It was in the stage of consultation that that happened after the first debate but prior to you becoming Minister for Health and Social Services in the second debate.

The Minister for Health and Social Services:

But it was part of the consultation process?

Policy Principal:
It was part of the consultation, yes.

The Minister for Health and Social Services:
The direction of travel has been decided by the consultation process.

Policy Principal:
Yes, it has been informed by feedback, both from the public and healthcare professionals.

The Minister for Health and Social Services:
Yes, informed by feedback. That is the most important thing, we acting on evidence. It is an evidence-based approach.

Director of Health Policy:
Absolutely. The previous Minister for Health and Social Services commissioned an ethical review which explored some of these differences. The previous Minister with the previous Council of Ministers considered the findings of that ethical review and collectively decided that we should progress developing proposals which provided for both assisted suicide and for euthanasia. Of course those proposals were laid before the States Assembly and the States Assembly agreed that legislation should be brought forward that provided for both of those modes of assisted dying. There has been complete transparency throughout the whole of the process and it has been a live issue giving live consideration throughout the whole of the process.

Deputy L.M.C. Doublet:
Okay, that is really helpful. Thank you for leading us through that.

Deputy P.M. Bailhache:
I would like to follow up on a question on that.

Deputy L.M.C. Doublet:
Yes, go ahead.

Deputy P.M. Bailhache:
Would it meet your policy intention, Minister, which is to allow people who wish to bring their lives to an end to do so to limit the euthanasia aspect of assisted dying to circumstances where the patient or the individual concerned was not able to self-administer? Would that beat your policy aim?

The Minister for Health and Social Services:

I do not think it would. If we have got in the legislation how it reflects the integrity of the process, then why would I, as an individual, seek to change that, bearing in mind I have to separate my own views from what the general process delivers? If that has been put out to consultation and the consultation is fed back that that is what the public would like in the legislation, I cannot see any reason why I would see fit to intervene or change that process. Is that the question you are asking me? Is it saying, would I see fit to move to change it to be just administered in the case where it has to be?

Deputy P.M. Bailhache:

No, the question was whether it would meet your policy aim, your policy aim being, as I understand it, to enable people who wish to do so to bring their lives to an end in the circumstances that the law describes. Would it not meet your policy aim if euthanasia, that is to say injection by a medical practitioner …

The Minister for Health and Social Services:

Yes, yes, was restricted, yes.

Deputy P.M. Bailhache:

… or a nurse, were limited to circumstances where the individual was unable to self-administer?

The Minister for Health and Social Services:

No, I do not think it would because I do not see why we would be restricting the rights of a person who wants to end their own life to choose the way in which they would like to end their life. As I say, if consultation is delivered that that is what the public want, I would certainly want to meet those needs. The answer to your question would be, I am afraid, no.

[12:30]

Deputy L.M.C. Doublet:

Can I clarify that your reason for keeping that in the legislation is to enable people to have the choice …

The Minister for Health and Social Services:

The choice, yes.

Deputy L.M.C. Doublet:

… of whether to self-administer or whether to have a practitioner administer? Was that reflected in all of the things that you have just mentioned to us?

Director of Health Policy:
Yes, yes, absolutely.

Deputy L.M.C. Doublet:
Was that examined and reflected?

The Minister for Health and Social Services:
My understanding, that has been part of the discussion, part of the consultation process and, as has rightly been suggested, that was part of what the Assembly decided to adopt. If we …

Director of Health Policy:
It is permissible in other jurisdictions.

The Minister for Health and Social Services:
Yes, yes.

Deputy P.M. Bailhache:
Safeguarding issues arise in the choice that you have made, which would not arise if the alternative were to be adopted. I am thinking in terms of coercion, for example. If you are self-administering, you are unlikely to have been coerced into doing what you are doing.

The Minister for Health and Social Services:
I cannot really foresee a circumstance in which you get 2 independent doctors and you would end up performing euthanasia.

Deputy P.M. Bailhache:
That may not be a good example, no, no.

The Minister for Health and Social Services:
I cannot envisage it and I will come back with some other comments but carry on, sorry.

Deputy L.M.C. Doublet:
We do have some questions on coercion where we can dig into this a little bit further. Minister, we have mentioned the evidence behind why that has been included in the legislation and also the safeguards to combat any problems that might arise. You have given us the detail of the safeguards

that are in there, for example practitioners being free to say they would like to participate in one or the other or both. Were there any other safeguards that were considered and rejected or do you feel that you have covered the safeguards as best you can?

The Minister for Health and Social Services:
I am personally comfortable. Anna, if you can remind us of any others that were considered.

Director of Health Policy:
I am so sorry, can I just clarify; are you talking about the safeguards relating specifically to practitioner-administered?

Deputy L.M.C. Doublet:
Yes.

Director of Health Policy:
Yes, okay. In the policy development work we did consider a number of options, including the option that Suzanne, the adviser, has just mentioned, which is about saying it is self-administered unless the person does not have the ability to self-administer. We did consider that option. We rejected that option on the basis of consultation with healthcare professionals who expressed concerns around the determination of, what did that look like? What did that mean? We rejected that because we felt that we should not be putting forward a piece of legislation where the professionals had uncertainty as to how they should operate within that legislation. That is the reason why we developed the legislation in the way that we did, which clearly provided for self-administration and administered-practitioner administration with the associated safeguard of the individual saying: "This is how I want it" and the practitioner saying: "Yes, I will do that or I will not do that." In addition to that, not only is there a right to refuse the administering practitioner, you may recall that at the point of administration there has be an administration witness. That administration witness can also refuse to witness an assisted death, which is a practitioner-administered assisted death. Yes.

Deputy L.M.C. Doublet:
Okay, okay. There were not any other safeguards for this particular aspect that you considered and rejected.

Director of Health Policy:
No more above and beyond the general safeguards relating to, what does coercion look like? Is it a settled wish? Is it a voluntary wish? Does the person have the capacity to understand the decision they are making? That is not just understand the decision relating to having assisted death but understand the decision relating to the mode of the assisted death. Yes.

Deputy L.M.C. Doublet:

Okay, that is really clear, thank you for that. We may come back to some of these points but I am going to ask my vice-chair to take the next section.

Deputy C.D. Curtis:

Okay. Firstly, if I could just refer back quickly to an earlier question about the concerns that had been raised by people with disabilities. You stated that there was a lot of protection against coercion and I just wanted to ask if that reassurance will be included in the information that comes out about assisted dying.

Director of Health Policy:

Yes, yes, absolutely.

Deputy C.D. Curtis:

Okay. I have got some questions about palliative and end-of-life care. Minister, can you confirm whether there will be a register of care navigators?

The Minister for Health and Social Services:

To the best of my knowledge, no.

Deputy C.D. Curtis:

No.

Director of Health Policy:

I wonder if I might ask for a little clarification. Are you talking about care navigators in relation to assisted dying? The care navigator is the role within the Assisted Dying Law of the professional who supports an individual to navigate the assisted dying process and to make the practical arrangements, such as making sure that they have an appointment with the assessing doctor. Is that what we are talking about or are you talking about professionals who support people who are accessing end-of-life care services, because those are 2 different things?

Deputy C.D. Curtis:

I am talking about the definition as provided in the draft law.

Director of Health Policy:

Okay.

Deputy C.D. Curtis:

Which is: “Care navigator, a non-clinical staff member who will support the individual requesting an assisted death and will support the co-ordinating doctor” and it goes on, but that is what I am talking about. Will there be a register?

Director of Health Policy:

As set out in the report to the Assisted Dying Law, care navigators, because they are non-clinical staff, they are employed and engaged by the assisted dying service. They have to go through the mandatory training but they are not assisted dying practitioners and they are not on the assisted dying register.

Deputy C.D. Curtis:

There will not be any register of them.

Policy Principal:

The only care navigators that will be employed will be those who are employed by the service. We anticipate that being maybe 2 people, for example.

Director of Health Policy:

Yes, yes, maximum.

Policy Principal:

If somebody were to act as a care navigator not employed by the service, they would be committing an offence under the law.

Director of Health Policy:

Yes, yes, yes.

The Minister for Health and Social Services:

The answer then would be, no, there is only 2 care navigators, so there is no …

Director of Health Policy:

Yes. While they are not on the register because they are not clinical professionals, at any point if someone was to say to the assisted dying service: “Who are your care navigators?” they would be able to say: “These are our care navigators.”

Deputy L.M.C. Doublet:

Clearly they are, yes, okay.

Deputy C.D. Curtis:

Okay, because they would be employed by the service.

Director of Health Policy:

Yes, yes, yes.

Deputy C.D. Curtis:

Okay. It is envisaged that access to a care navigator will be through referral by the health professional, so that is how it will work.

Director of Health Policy:

No. The law is very clear in that it does not restrict a person self-referring into the assisted dying service. It may well be that the individual talks to their G.P. (general practitioner) and their G.P. makes a referral to the assisted dying service on their behalf. But because of the issue of the right to refuse and, for example, their G.P. may object to assisted dying, so not refer them in, any individual can quite literally pick up the phone and self-refer themselves into the assisted dying service.

Deputy C.D. Curtis:

They can self-refer or they might be referred by a health professional.

Director of Health Policy:

Or they might be referred, yes, yes.

Deputy C.D. Curtis:

Okay. It is slightly different. Can patients be fully informed of care options if they have not been spoken to by an end-of-life care expert?

Director of Health Policy:

Yes. It is a requirement on the face of the law for both the assessing doctors and to take the co-ordinating doctor doing the first assessment and the doctor undertaking the second independent assessment, they must by law ensure that the individual has been fully informed of all of their end-of-life care options.

Deputy C.D. Curtis:

Okay, so that is the part of the law.

Director of Health Policy:
Yes, yes.

Deputy C.D. Curtis:
Minister, can you confirm whether the proposed end-of-life care law would be implemented before the Assisted Dying Law?

The Minister for Health and Social Services:
That would be the case, yes.

Deputy C.D. Curtis:
Yes, okay.

Director of Health Policy:
Pending the Assembly's decision-making, yes, yes.

Deputy C.D. Curtis:
Yes, yes, yes.

The Minister for Health and Social Services:
Take it as read, yes.

Deputy C.D. Curtis:
Yes, Nancy, do you want to speak?

Professor N. Preston:
Sorry, yes, just back to the point about being fully informed. If the 2 assessors might be a palliative care doctor or a G.P. with end-of-life care and experience, then that would be very possible to explore all the different end-of-life care options. However, we know in some jurisdictions we have obstetricians, for example, carrying out these assessments, who would be less well-versed in end-of-life care options. How would the law account for that?

Director of Health Policy:
The law accounts for that by requiring the assessing doctors to ensure that the individual is fully informed of all of their end-of-life care options. That, therefore, places an explicit requirement on the assessing doctor to understand what those end-of-life care options are. The law allows for that to happen by saying that the assessing doctors are under an obligation to seek what we have described in the law as a relevant opinion, i.e. to seek advice from a healthcare professional with

expertise to address any issues or gaps in that assessing doctor's opinion. The assessing doctor cannot say: "This is the limit of your end-of-life care options." If they do not have the experience to do that, they are required to seek a relevant opinion, which would most likely be from a palliative care expert in order to make sure the person is fully informed.

Professor N. Preston:

I was just thinking about the Jersey Care Commission's submission as well, who suggested it might be stronger and if it was enacted within the law that this was a requirement to have a palliative care assessment, rather than seek one if someone feels they need one.

Director of Health Policy:

Yes, we had noted the response from the Jersey Care Commission. The Jersey Care Commission have worked with us through the development of this legislation. It was not an issue that was raised by the Jersey Care Commission with us before. It was new information that was provided via that submission. We believe that the safeguards in the law and the requirements on the assessing doctor to seek all relevant opinions have the same net effect as a requirement and a specific requirement to always seek an assessment from a palliative care doctor, which may be duplication of that assessing doctor's expertise.

The Minister for Health and Social Services:

It does raise the question as to whether it would be ethically correct to force that on to somebody, to say to them you have to have an assessment, and I wonder about that being an issue personally, but not something that I would be comfortable with, I have to say, to say to …

Deputy L.M.C. Doublet:

You are not planning to make any amendments in that respect.

The Minister for Health and Social Services:

No, absolutely not because, as I say, I think some people could deem that as an affront. I personally would not want that to be imposed upon me. If I say I do not want an assessment that would be my right but, as I say, that is something that needs to be considered.

Deputy C.D. Curtis:

Okay. I suppose others might consider it is as receiving information that might be helpful to them. But I just wanted to ask a question now: what was the decision to introduce a statutory duty for end-of-life care rather than palliative and end-of-life care?

The Minister for Health and Social Services:

Is that not down to a decision by the Assembly?

Deputy L.M.C. Doublet:
In terms of definitions, we discussed this as a panel and we understand that palliative means it could be a longer term than a year and end-of-life care is limited to approximately one year before death.

The Minister for Health and Social Services:
The 12 months, it is my understanding too.

Deputy L.M.C. Doublet:
Yes. Yes, please proceed with your answer.

The Minister for Health and Social Services:
Sorry, can you reframe the question?

Deputy C.D. Curtis:
What was the rationale behind the decision to limit the duty to end-of-life care, rather than a broader duty encompassing both palliative and end-of-life care?

The Minister for Health and Social Services:
Ruth, you can articulate that better than I will, if you will.

Director of Health Policy:
The States Assembly when they debated P.18 back in 2024 made a decision and the decision that they made is that assisted dying should be available for people at end of life, people who are terminally ill.

[12:45]

The Assembly rejected the proposal that assisted dying should be available for people who were experiencing suffering but were not terminally ill. People who are experiencing unbearable suffering but are not terminally ill are likely to be people who are users of palliative care services rather than specifically end-of-life care services. The proposed new duty to provide end-of-life care directly tracks the States Assembly's decision-making on the boundaries of the Assisted Dying Law. It is appropriate in the sense that attracts that. There is also another issue, which is that palliative care for people who are not end-of-life is a healthcare services; it is about the care that they need to be able to live well. There are multiple other treatments, both treatments in care, for which the Minister for Health and Social Services is responsible, which there is no legal duty for the Minister to provide.

It seemed to be odd, unequal, unfair, whichever term you want to use, to provide a legal duty on the Minister to provide for palliative care and not provide for things such as cancer treatment. Hence the proposed end-of-life care law focuses very specifically on people at end of life because that is what the Assisted Dying Law does. Yes.

Deputy P.M. Bailhache:
Would it not be better to put the 2 words together and to talk about palliative and end-of-life care?

Director of Health Policy:
End-of-life care is palliative care just delivered in the last 12 months of life.

Deputy C.D. Curtis:
Okay. What I was just about to say is then in that case if there were ever to be an extension to the Assisted Dying Law to include people who also had unbearable suffering but not in the last year of life, there would be a requirement to extend that to palliative care.

Director of Health Policy:
Obviously a decision for the Assembly and the Minister at the time but I think, yes, absolutely that would need to be the case.

Deputy C.D. Curtis:
Okay. Minister, how will the proposed statutory duty to provide end-of-life care ensure equitable access to high-quality services across all care settings, including at home, residential care, in the hospital or a hospice, because this might be quite difficult I expect?

The Minister for Health and Social Services:
The plans are comprehensive, are they not? Ruth, you are best to run through that as well I think.

Director of Health Policy:
Sorry, could you repeat the question?

Deputy C.D. Curtis:
How will this duty play out across all these different settings to provide this equitable access to high-quality services? It might be at home or …

Director of Health Policy:
Okay. You mean in the event that the Assembly agreed that an end-of-life care law should be brought forward? Obviously we have got to develop, in consultation with key stakeholders, the

provisions of the end-of-life care law, but I think that on a very high level what we would see that law as doing is saying that when a person is in their last 12 months of life or it is believed that they are in their last 12 months of life, there will be a duty on the Minister to make sure that that person's end-of-life care needs are assessed and that that person's end-of-life care needs are met and that will be for all people. Obviously the detail of how those needs are met and where they are met will be subject to consultation, but I think if you look at the work that Jo and James have been leading on in terms of the End-of-Life Care Partnership and the End-of-Life Care Strategy, there is a clear commitment in Jersey to provide end-of-life care to people where people want to receive that end-of-life care. One of the things we know is that people at end-of-life almost invariably want to die at home and that is fundamental and hardwired into the work of that partnership group.

Deputy C.D. Curtis:
Sorry, did you want to ask a question?

Deputy L.M.C. Doublet:
I was just noting the time and I think we might need to maybe move a little bit quicker through some of our questions.

Deputy C.D. Curtis:
Did you want to move on to the next section?

Deputy L.M.C. Doublet:
I will leave it to you if you wanted to triage the rest of the questions in your section as best you can.

Deputy C.D. Curtis:
Okay. I just wanted to ask about the monitoring of the end-of-life care, how will that be done, the performance of how well it is going?

Director of Health Policy:
I wonder if I could hand over to Jo or James who are doing the work specifically on end-of-life care.

Associate Director, Improvement and Innovation:
Shall I start, James, and then you fill in on all of the details?

Chair, End-of-Life Care Partnership:
Sure thing, yes.

Associate Director, Improvement and Innovation:

For the implementation of the strategy on work that we …

Deputy C.D. Curtis:
Sorry, can I just say if you could speak as loudly as possible because I think some of the …

Associate Director, Improvement and Innovation:
Sorry, okay.

The Minister for Health and Social Services:
Pull the microphone in …

Associate Director, Improvement and Innovation:
We currently already publish a quarterly report on the implementation of the strategy and that is done. In terms of commissioning, we have quarterly meetings with our providers of end-of-life care and that is wider than just hospices, hospital, different providers of care. In addition to that, we have set up the partnership group, that I will let James talk about, which is even wider than just the commission services, a much broader monitoring. We have got detailed monitoring and it spreads out at different levels.

Chair, End-of-Life Care Partnership:
Yes, I think fundamentally the answer to the question is that is already in existence through those mechanisms that Jo describes in relation to how we are delivering on the End-of-Life Care Strategy. The feedback mechanism is there and it is formalised and it is reported on regularly. I am confident that that mechanism is there and in place and fit for purpose currently.

Deputy C.D. Curtis:
Okay, thank you. I want to skip some questions, if we could send them later in writing. I just wanted to mention about the Jersey Care Commission submission to us that has suggested more integration with palliative care when people are seeking an assisted death. Was there anything more that you wanted to say about that, just before I go on?

Director of Health Policy:
I do not think there is, beyond the fact that we are confident that the law requires the assessing doctors to ensure that people have access to the information they need about the end-of-life care options open to them. Also, just to say that there is an overarching principle that has governed all of this work around assisted dying and is clearly set out in all of the reports of the States Assembly, which is that a person who chooses an assisted death is not voting themselves out of end-of-life care. End-of-life care is end-of-life care and some people who are receiving it may choose to have

an assisted death. It is not the case that the people who are having an assisted death may choose end-of-life care. It is the other way round. That is the reason why when we first started to talk about assisted dying, the then Minister for Health and Social Services went to the States Assembly and said: "Please, may we have £3 million more per year for end-of-life care?" because that is the guiding principle of this legislation.

Deputy C.D. Curtis:
Okay. You would say that it is mandated in law that all palliative care options have been fully explored.

Director of Health Policy:
Yes.

Deputy C.D. Curtis:
Okay.

Deputy L.M.C. Doublet:
Thank you, yes.

Chair, End-of-Life Care Partnership:
Just into that point, for me this is all about choice. When we are talking about the choice of that mode of administration, that is held with the patient. When we are talking about that choice and that awareness of treatment options and palliative care as part of that, that is a patient-held choice. For me, I just really want to demonstrate that point that I do not think enforcing, as opposed to offering, should be the way forward.

Deputy P.M. Bailhache:
I do not want to put you on the spot but at some stage perhaps could you draw my attention to the article in the law which imposes this obligation on the …

Director of Health Policy:
I will do, I will do, yes, yes. I cannot remember it off the top of my head.

Deputy L.M.C. Doublet:
I suspect there will be a letter.

Director of Health Policy:
Yes.

Deputy P.M. Bailhache:

Can we move to talk about the End-of-Life Care Strategy? Are you satisfied that the strategy is developing well?

The Minister for Health and Social Services:

Personally from what I have seen, yes, yes.

Deputy P.M. Bailhache:

I wondered if you could provide an update on the impact of the newly-established Living Well Team and how it is providing co-ordination or improving co-ordination between generalist and specialist palliative care services.

Chair, End-of-Life Care Partnership:

Sure, I would be glad to take that point. I think it is acknowledging the difference between a specialist palliative care service being very much a service tailored towards delivering specialist care in relation to physical, psychological or spiritual symptoms a patient may have with a life-limiting illness. What we recognised very early on within the End-of-Life Strategy and its development is we had a large void of care delivery of those patients who were not imminently dying or those patients who did not have very complicated symptom-control issues but still had a met need. I think a real strength that we have been able to demonstrate from the output of the End-of-Life Care Strategy is the new service of the Living Well Team. This is a team of experienced palliative care nurses but not to the level of a specialist palliative care nurse or doctor that would help support a patient with a life-limiting illness and those close to that patient at a far earlier period in their disease trajectory. Patients are not waiting to develop complicated uncontrolled symptoms or be rapidly deteriorating towards their end of life before being able to access palliative care services. As a result of the End-of-Life Care Strategy, there has been a huge amount of enhancement of current services and development of new services that means that these patients can access a service before they ever were able to previously.

Deputy P.M. Bailhache:

Right. Is the 24/7 helpline being widely used?

Chair, End-of-Life Care Partnership:

Yes is the bottom line to that. We have always had 24/7 advice line available but that used to be delivered off-Island from palliative medicine doctors in Southampton. What we have seen though, in terms of that advice line now being offered through healthcare professionals on Island, is the uptake has been exponential. Whereas we may have seen calls through to an off-Island advice line

measured in a dozen a year, we are now seeing that over a weekend, for example. I think healthcare professionals who provide the specialist palliative care service day in, day out, based on Island, in terms of that familiarity and that confidence that healthcare professionals accessing the advice line have in knowing who they are calling, has been a really positive step in terms of it being utilised far more effectively than the previous model of an advice line provided off-Island.

Deputy L.M.C. Doublet:

Thank you for those answers. We have a section now on public awareness, which is something that the panel have been weighing up and, Minister, paragraph 10 of the draft law states that: "The service will provide information and support for all Islanders, including online and printed material." Can you clarify what types of information will be made publicly available? Explain to us how this is balanced with Article 50, which sets out an offence to advertise or promote assisted dying.

The Minister for Health and Social Services:

Okay. Forgive me, I know you are addressing all of the questions to me, which is fine but I think I am just going to pass. These require proper answers and I am just going to refer them straight to Ruth, if you can advise me whether you or Anna in that instance would be better …

Deputy L.M.C. Doublet:

I can rephrase briefly. Basically, we are looking at where the law requires there is information put out there but it also says that promoting the service is an offence. We want to understand what the balance is there and what types of information will be put out there. I suppose to ensure that no one is prosecuted for providing information that they maybe thought was genuinely okay to do under the law, is that …

The Minister for Health and Social Services:

It makes sense. Yes, it makes perfect sense.

Deputy L.M.C. Doublet:

Okay.

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.”

[13:00]

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.

Deputy L.M.C. Doublet:
Will that be part of the training package that there be actual examples like that that practitioners will have access to so that they can determine themselves how to stay on the right side of the …

Director of Health Policy:

Yes, absolutely. You may recall from the detail in the law that not only is the Minister under an obligation to provide training to assisted dying practitioners but also to make training available to all healthcare professionals, optional training available to all healthcare professionals on the Island. Some of the things that will be considered within that training is: what is the law saying about promoting assisted dying?

Deputy L.M.C. Doublet:

Okay, that is reassuring to hear that. Thank you. We also …

Deputy P.M. Bailhache:

Can I just interject with a question?

Deputy L.M.C. Doublet:

Yes, go ahead.

Deputy P.M. Bailhache:

I am interested to hear what you say about the medical practitioner with a poster on his wall saying about assisted dying because it does not seem to me that the law prohibits that state of affairs. What Article 50 says is that: "A person commits an offence if they promote or advertise assisted dying (a) by intentionally giving information that breaches 78(3)(a) or with an intention of breaching 78(3)(b)." 78(3)(b) is not relevant but 78(3)(a) says that: "A person who promotes or advertises assisted dying or the service may do so only by giving information about the availability of assisted dying and related services and about where more information on assisted dying can be found." It does not seem to me that it prohibits what you are hoping that is not going to happen.

Policy Principal:

Sorry, can I just interject?

Director of Health Policy:

Yes, go for it.

Policy Principal:

It is just to point out you said 78(3)(b) was not relevant but what 78(3)(b) does is it says: "But they must not do so with the intention of persuading or encouraging anyone to have an assisted death." I think the example that Ruth gave about: "Come here and I can help you have an assisted death" would likely be considered the intention of persuading or encouraging someone to do so.

Deputy L.M.C. Doublet:

Okay. Yes, it is a tricky one, is it not? On the flipside of that, if practitioners are wary of providing information, is there a risk that some Islanders might not know that the service exists or have access to the information?

The Minister for Health and Social Services:

It is a fine balance, is it not? Hopefully, the balance has been struck, in other words, is the right one, because it is clear that you can provide information. Hopefully, people would sensibly use that correctly.

Director of Health Policy:

That is the risk, which is why it is envisaged the assisted dying service will produce appropriately drafted crafted information about the assisted dying service.

Deputy L.M.C. Doublet:

You would expect that the service, given that it would produce its own leaflets, I am assuming a website, possibly posters or …

Director of Health Policy:

I think that level of detail is something that we would need to work with individual healthcare providers to talk about what appropriateness of that looks like in the event that the law is adopted.

Deputy L.M.C. Doublet:

Yes, okay, but the materials would be able to just be sourced from the service.

Policy Principal:

I think that would be the intention on obviously not just healthcare providers but other organisations that support people to access information such as assistance type organisations or charities that support people.

Deputy L.M.C. Doublet:

Okay. There would not be a charge for these materials, would there?

Director of Health Policy:

No, no.

Deputy L.M.C. Doublet:

No, okay. Okay. I am assuming that this will be monitored as the law is embedded. Is that something you are planning to do, Minister, to monitor the awareness of the legislation and access to information to see if any improvements need to be made?

The Minister for Health and Social Services:
I expect that to be done but I do not know if it is formally documented that we would do that. Is there anything that is specified that we would do that?

Director of Health Policy:
On the face of the law, there is nothing specified on the face of the law but, of course, it would be good practice and the assurance at the assurance committee that will be set up will look at matters relating to that. I think it is the case that if people were concerned about any organisation or any individual potentially overstepping the mark in terms of promoting assisted dying we would hear about it.

Deputy L.M.C. Doublet:
Okay, thank you. I have just got one final question on this section and it relates to Islanders with disabilities who may need their information in different formats and also maybe Islanders with additional languages. Minister, will you ensure that that information is available in the broadest possible forms and languages so that it is accessible?

The Minister for Health and Social Services:
The only reasonable thing to do, absolutely, yes.

Deputy L.M.C. Doublet:
Thank you.

Director of Health Policy:
Just to say related to that, of course the law does provide an obligation on assisting doctors to make sure that if people have communication needs, for example, whether it is a special language or they need signing or whatever that may be, there is an obligation to provide communication support needs to people once they are in the assisted dying process.

Deputy L.M.C. Doublet:
Okay, thank you.

Deputy C.D. Curtis:

Okay. I have a question about the training for professionals. Outcome 1 of the action plan commits to continuing the development of the Gold Standards Framework across community and hospital healthcare professionals. Does the Minister consider that adequate funding is in place to support this?

The Minister for Health and Social Services:
I think there is but I do not know …

Chair, End-of-Life Care Partnership:
When you refer to the Gold Standards Framework, it is for the benefit of everyone. This is a framework with information-sharing that utilises prognosis to make healthcare professionals and those surrounding patients aware of their likely prognosis. Accreditation has been received from the G.S.F. (Gold Standards Framework) Committee in terms of the delivery of that specific piece of education already and that is being rolled out.

Deputy C.D. Curtis:
That is okay. Has provision been made for any ongoing training updates, any updates to this work?

Chair, End-of-Life Care Partnership:
In relation to the End-of-Life Care Strategy, yes, there has been a significant increase in terms of the delivery of palliative and end-of-life education throughout the Island in all different care environments, not just to healthcare professionals, doctors and nurses and allied healthcare professionals but also non-qualified carers and accessible information and education to those surrounding patients, friends and family. There is a firm commitment in relation to the ongoing infrastructure to support education across all areas in which patients with life-limiting illnesses in Jersey sit.

Deputy C.D. Curtis:
Okay. That seems completely sufficient, okay. Thank you.

Deputy P.M. Bailhache:
May I ask some questions around the safeguards for practitioners? Article 36 of the law sets out the right to refuse to participate in relation to an assisted dying practitioner, participation may not be refused in any exceptions. What happens if the assisted dying practitioner changes his mind? At what stage, does he have to give any notice? Can he do it at the last moment?

Director of Health Policy:
Change their mind as in decide they do not …

Deputy P.M. Bailhache:
Not to participate.

Director of Health Policy:
You will have to excuse me, there is buried somewhere in the law, and I cannot remember the exact article but we can reference you through and provide this information afterwards, about any assisted dying practitioner's right and ability to step out of an assisted dying process during the course of that process. Anna, can you recall off the top of your head …

Policy Principal:
Are you referring exactly to the changing of a practitioner?

Director of Health Policy:
Yes, yes, yes.

Policy Principal:
No, but I can find it quickly.

Director of Health Policy:
The law does provide for practitioners to change and that can be where an assisted dying practitioner for any reason has decided that they no longer want to be involved or should be involved, for example in a case of conflict, in assisted death.

Deputy P.M. Bailhache:
That can be done at any stage.

Director of Health Policy:
Yes, yes, yes. We can provide the pathway through the law that allows for that information on that.

Policy Principal:
That is Article 35 is the change of practitioners.

Deputy P.M. Bailhache:
Paragraph 213 of the report refers to: "Operational guidance and training for professionals in exercising their right to refuse." Can you give some indication, please, as to what that guidance will include and whether it will all be clear?

Policy Principal:

As well as 213 of the main report, the addendum also gives some more information about the training and guidance. The exact nature of what that looks like is a matter if the law is adopted for the implementation phase. In terms of exactly what that will look like, as we mentioned before, there are 2 facets to that. There is the training that will be provided to those who choose to opt into being an assisted dying practitioner. There is also this training that will be made available to all healthcare professionals on Island which will step through that option to refuse.

Deputy P.M. Bailhache:

Okay. I think that is it for now.

Deputy L.M.C. Doublet:

Okay. I have a follow-up. We had a submission from the British Medical Association and I am not sure if this has subsequently been addressed in the law but perhaps you could help with that. They raised employment protections and the example they gave was that a doctor who works 3 days a week as a G.P. but is also contracted with the assisted dying service would not appear to be protected if they apply to be a partner in another practice and were rejected because of …

Director of Health Policy:

This has been addressed in the version of the law that is lodged because the law not only provides employment protections but it provides protections for partners. We amended the law very specifically because of that feedback that we received from the professional registration body.

Deputy L.M.C. Doublet:

Okay. Thank you for clarifying that. I appreciate that. I have some questions around coercion, which is another theme that has come through in the panel and previous debates and discussions. Minister, the guidance for healthcare professionals. We note that indicators of possible coercion is something that you have said will be included in that guidance for the healthcare professionals. Will there be a clear definition of what coercion is to ensure the consistent understanding of what it is specifically in the context of assisted dying?

Director of Health Policy:

Coercion in all contexts but also in the context of assisted dying can be many things and it can take many forms. The guidance will not define coercion per se but what it will do is it will provide details as to what coercion may look like, what indicators and what indicators of coercion may be, and also, the relationships or the balances of power in which coercion may occur.

[13:15]

Obviously relating to the actual law itself, because there are some direct read-acrosses, is it is entirely possible for someone who has requested an assisted death to say to the assessing doctor: "I do not want you to talk to any of my family members about this." We recognise that that, therefore, potentially allows for coercion. What we are very clear about is if the individual says, for example: "You cannot go and talk to my spouse about my request for an assisted dying", that the doctor must inform the person that their inability to talk to family members may mean that the doctor cannot assess the person as eligible for an assisted death. The assessment doctor must be satisfied that the wish is voluntary, i.e. it is free from coercion, not that they have not uncovered coercion. It is a positive requirement to satisfy themselves of this matter.

Deputy L.M.C. Doublet:
It is quite a high bar to …

Director of Health Policy:
Yes, yes, yes.

Policy Principal:
Yes, just to add to what Ruth is saying and that is one of the reasons why the definition of coercion is not as essential. What is essential is that the decision is voluntary and that the assessment doctor is sufficiently satisfied of that. If there are any doubts, so they cannot be satisfied of that, they cannot assess them as being eligible, so they would not meet the bar.

Deputy L.M.C. Doublet:
Okay, so it has to be really thorough.

Policy Principal:
Yes.

Deputy L.M.C. Doublet:
Okay. This is adjacent to this issue but I noted in the V.A.W.G. (Violence Against Women and Girls) taskforce report update, obviously coercion is something that we have raised in the V.A.W.G. report. I believe that at the time of that update the training needs analysis had not been undertaken by various agencies and, therefore, training around coercion has not been initiated. That may not be true for all agencies. But, Minister, is there anything that you will do or you are planning on doing in terms of joint working, given that this is a factor in other areas, in other Ministerial departments to work together?

The Minister for Health and Social Services:
I have not got anything planned for that but, Ruth, as I say, these are points of detail that are best answered by …

Director of Health Policy:
Obviously for assisted dying everyone who works in assisted dying must be trained in coercion. The Minister must provide training, make available training, optional training to all other care providers which will deal with coercion. But I think that it would be beholden on the Minister to ensure and do everything possible to ensure that there is general uptake of coercion and safeguarding training, as provided through V.A.W.G.

Deputy L.M.C. Doublet:
Thank you. Minister, would you seek to initiate a conversation perhaps with the Minister for Home Affairs to identify areas where you could work together or where perhaps future Ministers could work together in that respect?

The Minister for Health and Social Services:
Certainly able to do that, yes, absolutely.

Deputy L.M.C. Doublet:
Thank you. If you could update us on those conversations, we would be very grateful.

The Minister for Health and Social Services:
Will do, okay.

Deputy L.M.C. Doublet:
I do have a supplementary which I will try to word in a way that everyone can understand. I was trying to understand the definition of close relatives that is in the definitions of the legislation and it applies to, I think, conflicts of interest. It just brought something to mind in one of the answers around positions of power and authority. Is there anything in the law that defines somebody who might be in a position of power or authority but is not a close relative and how that would interact with the legislation? If that is not clear, we can come back to you.

Director of Health Policy:
There is nothing in the law that defined that because I think it is almost undefinable, but within the guidance, the guidance will be really detailed, and the guidance will look at matters relating to what does imbalance of power in a relationship look like? There is one part of the law that does touch on balance of power in terms of hierarchy, which relates not to the individual person who is having an

assisted death but to the relationship between the co-ordinating doctor and the independent assessment doctor, which is that the independent assessment doctor is required under the law to disclose any hierarchical relationship with the co-ordinating doctor which may call into question their ability to make an independent assessment. We have acknowledged hierarchical relationships within the relationship between the co-ordinating doctor and the independent assessment doctor.

Deputy L.M.C. Doublet:

That is good to hear. Thank you and, of course, in Jersey, Minister, I am sure you will agree that the level of detail in terms of the safeguarding, that is critical, is it not, on a small Island?

The Minister for Health and Social Services:

Absolutely, yes.

Deputy L.M.C. Doublet:

Thank you, and I know that in other legislation - I think it is the sexual offences legislation - there are some definitions of relationships where there might be a power imbalance in terms of coaches and teachers and things, so it is possible to do. I suppose all I would ask is that, Minister, you would ensure that there is clear direction from yourself to make sure that that is included in the training, which it sounds like it is.

Director of Health Policy:

Yes.

Deputy L.M.C. Doublet:

Thank you. Okay. I am going to move to Deputy Curtis again for a question.

Deputy C.D. Curtis:

Okay, if I could just refer back to questions that were asked about the right to refuse to participate by a practitioner, I think in the law there are also assertions that the administering practitioner cannot refuse to administer the approved drugs to the individual if the practitioner previously agreed to do so. Does that not confuse the issue about … I think you were saying they have the right to opt out at any time.

Director of Health Policy:

We talked earlier about the difference between assisted suicide and euthanasia. The law allows an administering practitioner to say: “I will not administer the drugs. I will not participate in what some people call euthanasia, but I will support the person to self-administer the drugs.” They have a right to refuse to participate in euthanasia but, within that right, a person who is generally very sick, very

ill and at end of life really should be able to anticipate that an administering practitioner will not say: "Yes, I will do that" on Tuesday and then change their mind on Wednesday. That is inherently unfair on the patient, so what the law says is an administering practitioner can refuse to do that but not if they have already said that they will do that and that is based on the individual person's case, not the general principle of it. Is that clear?

Deputy C.D. Curtis:
Yes, I do understand your point but that means that they do not have the right to opt out in all cases. Do you think that there should be more clarity in the law around that?

Policy Principal:
It is very much around the timing in the process as to when this occurs, the point at which exactly what the assisted death will look like is agreed in the care planning phase. After they have had approval but before the death date, they decide all of the details about it. If the individual says: "I want it to be administered to me; I do not want to do it myself" at that point, if the administering practitioner says: "Sorry, that is not what I want to do", they can absolutely opt out. If, to Ruth's example, they say: "Yes, fine. I will do it. I will administer it to you", and then the night before they change their mind, that is something that they will have considered and, as Ruth said, in fairness to the individual will be required to proceed. The likelihood of a practitioner changing their mind having agreed to it is extremely low.

Deputy C.D. Curtis:
It is very low but if that were to happen, the practitioner could not be made to do that, so what would happen to them then?

Policy Principal:
They would have a duty to do it under law. That is where the exception does not apply.

Deputy C.D. Curtis:
They could not be made to do it though.

Policy Principal:
The likelihood is, say if that were to happen, a very unlikely situation, that practically the service would probably be able to arrange for an alternative practitioner to do it.

Deputy C.D. Curtis:
Okay.

Deputy L.M.C. Doublet:

Can I just expand on that? Minister, do you think it is appropriate to keep that provision in the law that states the practitioner is still required to administer that service if they change their mind for ethical reasons?

The Minister for Health and Social Services:

It is an awkward one but I think on balance, yes, because I am just wondering as this discussion has developed what would happen if you are bringing in someone else in the place of the person to administer that who has not been through the process themselves but who might want to say: "You are asking me today at short notice to administer a terminal procedure to somebody and I have not been involved in this process at all." Forgive me, this is something that has not … you do well to raise this because I rather fancy there could be a potential problem if somebody pulled out at the last moment and somebody is waiting for that procedure, for the person that comes in and says: "You are inviting me to do something and I have had no part in this process", and that could be a complication. I think having an obligation on somebody to carry it out once they have made the commitment to do so is probably, on balance, the right and proper thing to do in light of the thinking that has just come to mind during the course of this conversation.

Deputy C.D. Curtis:

Yes, it would be the right thing to do but at the same time, somebody might still refuse to administer.

The Minister for Health and Social Services:

In the event that they do, perhaps we should give some thought to provision for considering what might happen in that scenario. Forgive me, that is something you may have looked at but have you considered what might happen in the event that somebody … like you say, you cannot physically make somebody …

Director of Health Policy:

No, we cannot. Absolutely fundamental, and this goes back to the point James was making, the whole purpose of the assisted dying service is to provide people with choice at the end of life and to provide them with compassionate, sensitive care and realisation of their choice. There is absolutely no way we would want any patient to be forced to have to engage with an assisted dying practitioner who was not willing and happy to support that patient to realise their wishes. The assisted dying service would work to ensure that that never happens because everything about this service is about supporting people to realise their wishes to take control at the end of their life. It is about compassionate healthcare, and we would ensure that the service delivers right and appropriate compassionate healthcare.

The Minister for Health and Social Services:

With the best will of the world you do raise a good point because … and it is very, very unlikely and I appreciate that but in the event that somebody said one day: "I am going to deliver this", and then the next day said they were not going to, in that very, very unlikely event I think we should perhaps give some consideration to how we line someone up. The preparatory work we do to make sure that in the event of that to rightfully deliver what you have very well-articulated is sensitive and proper care for people that, we do consider a backstop situation as to how we could move in and not make that person have to wait X amount of days when they are expecting a service. I just think it is something we should give a little bit of consideration to, but I do not know if you think that is sensible.

Director of Health Policy:

Yes, absolutely, and there are end of life review processes hardwired into the review so that would clearly identify any of those issues. Those issues would be accelerated to the committee in any event.

The Minister for Health and Social Services:

It may require that you have to have somebody, just somebody who has also agreed to deliver that type of service, to be kept in parallel in the last moment as a standby so that they have got the background to the situation, so that you have got somebody who can readily step in, so that the patient is not subjected to any unnecessary …

Policy Principal:

This would be an operational matter for implementation because the likelihood is you might want that anyway because it may be that they are taken ill and so that contingency back-up I anticipate will be part of developing the service.

The Minister for Health and Social Services:

Your administering doctor might get knocked over by a bus. You just do not know, so that is an eventuality that we need to consider and something we are happy to do and probably do that sooner rather than later.

Director of Health Policy:

As we said, the law allows someone else to step in as required.

Deputy L.M.C. Doublet:

The law does allow that contingency.

Director of Health Policy:

Yes, it absolutely does.

The Minister for Health and Social Services:
You just need to make the practical provision for that to happen without any interruption or any difficulty for the administering doctor.

Deputy C.D. Curtis:
Something like this might happen if there has been a waiver of capacity and the family are concerned. As time approaches, on the last day or so, there may be all sorts of objections raised.

The Minister for Health and Social Services:
The practitioner might have a heart attack on the way to the …

Deputy C.D. Curtis:
It might make the practitioner feel very uncomfortable and I do not know if the G.M.C. (General Medical Council) would be happy with this obligation on a practitioner that they cannot opt out towards the end.

The Minister for Health and Social Services:
Personally, I think the obligation should remain. I do, because you do not take this sort of thing on lightly and I do not think it is fair to the patient to have somebody that might just …

[13:30]

Deputy C.D. Curtis:
Okay.

Director of Health Policy:
The G.M.C. have not raised any direct concerns about this but, as I mentioned earlier, Anna is going through a process of just checking some matters with them and we can add this to those matters because the Minister is very clear that if we need to make some minor amendments to the law to address matters like that, we will do so.

The Minister for Health and Social Services:
We will do it. Yes, absolutely.

Deputy C.D. Curtis:
Could that be looked at?

Director of Health Policy:
Anna can add that to her list. Yes.

Deputy C.D. Curtis:
Do you want me to do these now or leave it for now because of time?

Deputy L.M.C. Doublet:
I think we can possibly follow-up, can we not, in writing. Okay, thank you. Will you update us on those conversations as they proceed?

Director of Health Policy:
Yes.

The Minister for Health and Social Services:
Happy to do that.

Deputy L.M.C. Doublet:
Thank you. We will move to …

Deputy P.M. Bailhache:
Can I come to the controversial area of waiver and as a preliminary ask whether when the survey of healthcare practitioners took place in early 2025 and doctors and nurses were asked whether they would be willing to be an administering practitioner, were they specifically asked whether or not they would be prepared to act in the event that this waiver of future capacity had taken place?

Policy Principal:
Do you want me to answer that? In terms of the survey participation, 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.

Deputy P.M. Bailhache:
It was not specifically put to them.

Policy Principal:
It was not a specific question to them.

Deputy P.M. Bailhache:

No. Are you, Minister, confident that there has been sufficient discussion of this waiver of future capacity?

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.

Deputy P.M. Bailhache:
Article 9 of the draft law provides that: "The administering practitioner may not continue with the administration of the substance if the individual demonstrates a refusal or the resistance to the administration by words, sounds or gestures and reflexes, movements and involuntary movements would not count as gestures." We are into quite a difficult …

The Minister for Health and Social Services:
We are.

Deputy P.M. Bailhache:
… sensitive area, are we not, where if somebody moves a hand, you do not know whether or not he is indicating a refusal to go along with it or not. Does that not undermine the whole issue of personal autonomy?

The Minister for Health and Social Services:
You mentioned that we are into very difficult territory. I will give you an example: I watched my father die of pancreatic cancer, and he had to die of dehydration over a 6-day period and that was pretty grim. Had my father had the opportunity to opt for assisted dying and he had signed the waiver, I think he would have been quite happy to be released from that pretty pitiful situation. I appreciate we are into difficult territory here but that is where we, are so on balance, I am comfortable.

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

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.

Deputy P.M. Bailhache:

It does mean, does it not, because numbers of people change their minds at the last moment, it seems, from the experience of other jurisdictions. There is quite a significant percentage of people - I cannot remember exactly what it is, 28 per cent or something like that - who have gone through the process and changed their minds at the last moment. Those people who have gone through the process and waived the requirement for future capacity might very well find themselves put to death when they did not want that to happen.

The Minister for Health and Social Services:

One has to assume then that they would have changed their mind as they drifted into unconsciousness. Maybe they have or maybe when they are unconscious, they change their mind, I do not know, but I think we are looking at circumstances, I would have thought, where most people who have opted for the waiver slip into unconsciousness because they are on heavy doses of morphine. As I say, I have seen this in my own case, at a point where you do not reduce the morphine because that is the state that the person has reached. In practical terms, the likelihood of that happening is very, very, very slim and if somebody has signed a waiver, I think it would have been in anticipation of the fact that what they would wake up to would be worse than not waking up at all. I just foreword that as you have asked for a personal opinion and that is all I can offer you, I am afraid.

Deputy P.M. Bailhache:

Do you think that there is a risk that administration being what it is that doctors will get into the habit of saying to a person at the appropriate stage, stage 6 or step 6: “Here is waiver form. Do you want to sign a waiver form in the event that you lose capacity?”

The Minister for Health and Social Services:

I am not sure that that is the way that a practitioner would go about this. I think what a practitioner would do is make available to them at the beginning of the process all of the information. It is probably unlikely that somebody would then go up to someone and say: “Do not forget the waiver. Why do you not sign this?” That would probably not be the correct way for the practitioner to go about the process, so I would envisage a potential patient being given the information and being able to utilise that information but, as we have said before, not be actively encouraged to do anything. As I say, so long as it is carried out in the way that it is specified, I do not see this as a risk factor.

Deputy L.M.C. Doublet:

Could I ask, to clarify, what might that look like at that stage in the process where the waiver is being discussed in the situation that the Deputy is describing? Will the full implications of the signing of the waiver be fully explained? What might that look or sound like?

The Minister for Health and Social Services:

We would certainly envisage that but perhaps you can give some more detail on what is prescribed.

Director of Health Policy:

Yes. There are a number of things that are quite important to understand. The person will be asked if they wish to sign a waiver but signing a waiver in itself does not mean that the assisted death will take place. During the care planning phase, the person will be asked to sign the waiver, and they will also have, at that stage, to say: "I am confirming that I am making my final request for an assisted death." The administering practitioner must be absolutely satisfied that the person at the point at which they are saying: "I am signing this waiver because I am making my request for an assisted death", that they have capacity to make that decision. They cannot sign a waiver unless they have said: "Yes, I want to proceed and yes, I have got the capacity to make this decision." It is …

Deputy L.M.C. Doublet:

They are taking responsibility for that, in effect.

Director of Health Policy:

They are taking responsibility for that. At the point at which the assisted death is taking place … and it is really important to recognise the timeframes in most of these processes. The timeframes are days; they are not weeks or months. They are days in most cases but at the time of the assisted death, if the person has signed the waiver but the administering practitioner is not satisfied that they wish to proceed - so those gestures we have spoken about - the administering practitioner can halt the process. That does not mean to say it is halted for ever and a day. They can then return back to the person to establish whether or not it is appropriate to proceed at a different stage. Capacity at the end of life is often fluctuating. It is fluctuating because of the person's ill health, and it is fluctuating because of the medication that they are on. We have designed a law that allows the administering practitioner to make in-the-time decisions about whether or not they believe it is appropriate to proceed. You were asking whether or not we have consulted and discussed this waiver with healthcare professionals. We have done. We have done extensively, including with the working group that James is the chair of, including with the Professional Leads Group. We have also discussed it with the assisted dying practitioners in other jurisdictions, who are current practitioners of assisted dying who have lived experience of supporting people to have an assisted death. They are very clear about the importance of providing a waiver at the end of life because

one of the things that they have said to us is there is almost nothing worse than turning up on the day to either administer or support a person to self-administer and with their family and friends around them to say: “I am really sorry, your loved one had capacity yesterday when they made this decision but they have lost capacity as a result of the medication they are on and their drugs”, and to not proceed with that assisted death not only for the person but for their loved ones around them and the associated trauma. We have discussed this with healthcare professionals, and we have worked really hard to listen and to understand what they have said and we have been very clear about the waiver. It was part of the report and proposition that went to the States Assembly.

Deputy P.M. Bailhache:
A waiver can be withdrawn at any stage, can it not?

Director of Health Policy:
Yes.

Deputy P.M. Bailhache:
The circumstances that you describe are well understood but at the same time, different circumstances, where a person has lost the physical capacity to communicate but not the mental capacity and has changed his mind and does not want it to go through, he cannot stop it.

Director of Health Policy:
They can if there are gestures of refusal.

Deputy P.M. Bailhache:
If he is capable of making a gesture that is understood by the practitioner as being something that indicates dissent. If he cannot do that, that is bad luck.

Chair, End-of-Life Partnership Group:
I would probably just come in, if I may, and pick up your point about the risk that you are identifying that somebody, in your words, Sir Philip, could be put to death unable to communicate the decision that their choice had changed in that period. From my perspective, there would be a very fair assumption that if somebody had continued to clinically deteriorate to the point in which they could not speak and they lose capacity and that capacity does not return, that associated with that deteriorating function would be a deteriorating mental function. It would be very unlikely that they would maintain cognitive ability to be making a different decision in the context of their body failing and fading to the degree in which they could not verbalise or recognise around what was happening. Our assumption here is saying that somebody would maintain the cognitive ability to change their mind despite losing capacity and the ability to communicate. From my perspective, if somebody

was deteriorating to the point in which they could not talk to me, then there is a very strong assumption that they would not have the cognitive ability to be thinking about such a complicated topic and making a different decision by the default of how poorly they were in losing the capacity that they lacked.

Deputy P.M. Bailhache:
As assumption but not certainty.

Chair, End-of-Life Partnership Group:
I do not think in healthcare you can be certain about anything.

The Minister for Health and Social Services:
In human terms, it is difficult to imagine a scenario where you cannot even make the gesture of blinking your eyes where you would want … I certainly would not want to continue in that situation.

Policy Principal:
I think to James's point, it is not like, for example, someone having a car accident and being in a coma and having mental capacity.

The Minister for Health and Social Services:
No, very, very different.

Policy Principal:
It is different with a terminal illness at the end of life.

[13:45]

Director of Health Policy:
Sorry, the other thing, just if I may, to pick up on the statistics about people who have an approval for assisted death but do not proceed to the assisted death, which is around 25 to 30 per cent, just to be clear, that includes people who choose to change their mind but it also includes people who died before they get to the stage of having assisted death. It is probably a larger percentage of those people just reached their natural end of life before they have the assisted death.

Director of Health Policy:
They can have changed their mind at any time before the assisted death. It is not necessarily on the day.

Deputy P.M. Bailhache:

The difficulty is that there are incidences where these kinds of circumstances have been recorded, are there not? I forget, I think it was in Holland or in Belgium, one of those 2 countries, there was a case where there was a confusion as to whether or not the old lady had indicated a dissent or a refusal, and she was put to death. I should not use that expression, perhaps, but she was treated and these was subsequently a judicial inquiry as to what had happened. One of the presentations that I went to explained that in some detail.

The Minister for Health and Social Services:

The use of terminology is important, and you did correct yourself when you said: "Put to death", but one could also articulate that by saying that her wishes were carried out, and I think that would not be unreasonable. I just wonder what the outcome of the review was because it would be very difficult to have ascertained postmortem what the intention …

Deputy P.M. Bailhache:

I think I recall from the presentation that the outcome of the review was that the future practice should not be to give the injection when the signs of distress or whatever were being …

Director of Health Policy:

Which is what our law provides for.

The Minister for Health and Social Services:

Here we have any sign of distress at all should be taken as an assumption not to continue. Is that not right?

Director of Health Policy:

It is.

The Minister for Health and Social Services:

That safeguard, I think, is already in place here.

Deputy P.M. Bailhache:

Okay.

Deputy L.M.C. Doublet:

In terms of the numbers of people that might be asking for a waiver, are you aware of anything from other jurisdictions that indicates … some of the evidence that we have from our advisers indicates

that only around 3 per cent of people ask for a waiver in territories where it is permitted. Is that something …

Director of Health Policy:
It can be really difficult to get any kind of real evidence about the specific details of assisted dying in another jurisdiction but, from what we understand, it is very, very small numbers.

Deputy L.M.C. Doublet:
If it is such small numbers, Minister, that might access this and given some of the concerns raised, do you feel that you still want to include this in the legislation?

The Minister for Health and Social Services:
Absolutely.

Deputy L.M.C. Doublet:
Can you explain why you feel it is important?

The Minister for Health and Social Services:
In the modern world, we put a lot of emphasis on minorities and minority rights, and this is just another case. It might be a small minority of people but why would we not listen to them?

Deputy L.M.C. Doublet:
Anything further on that? No? Okay, thank you. I want to ask some questions about the death certificate and identity of the practitioners. Minister, could you help us to understand how or whether the death certificate that is published will keep the identity of the certifying doctor or the assisted dying practitioner confidential or whether that would be published?

The Minister for Health and Social Services:
These are more detailed questions. Once again, I will hand them over to either you or Anna.

Policy Principal:
There is a distinction between those 2. The certifying doctor is the doctor who completes the medical certificate. They would be the one signing the certificate so very much they are the one carrying out that process. In terms of the administering practitioner who is the one who either supported the person to administer or administered the medication, there would not be any read-through into the death certificate to identify an individual doctor in terms of the fact that they administered the medication.

Deputy L.M.C. Doublet:
Okay, so would they always be 2 different people?

Policy Principal:
Yes, very much so. That is an important safeguard that the certifying doctor is not the one carrying out the act.

Deputy L.M.C. Doublet:
Okay, so the assisted dying practitioner, that is confidential.

Director of Health Policy:
The law prohibits anyone putting any information into the public domain about an assisted dying practitioner unless the assisted dying practitioner has consented to that information being put into the public domain.

Policy Principal:
That information would go to the post-death review panel so they can be aware of trends in terms of activities of the practitioners, their review processes.

Deputy L.M.C. Doublet:
Okay. Thank you.

Deputy C.D. Curtis:
I have just got some questions about reviewing and monitoring of the service. Given there is a small number of cases expected, have you considered reviewing all requests for the assisted dying service within the first 3 years of running the service to be reviewed?

Director of Health Policy:
The law provides for oversight of the assisted dying service in a number of different ways but one of the things it very particularly does is it says that there must be a review panel and the review panel must review every single assisted death that takes place. There is an explicit requirement on them to do that for ever and a day to review assisted deaths that took place to look for any patterns or concerns, whether that is about the sorts of individuals having an assisted death or if that is about the practice of the doctors. The law then also provides that the review panel may review any requests for assisted dying that do not result in an assisted death, whether that is because the individual changes their mind or whether that is because the person dies before the assisted death takes place. The law allows for either of those things to happen. The law also says that the assurance committee and the Minister can place requirements on the review panel to review those

assisted dying processes that do not result, but when it comes to ones that result in an assisted death, for ever and a day, not just for 3 years, for eternity, there will be a review of that process.

Deputy C.D. Curtis:

Okay, so every assisted dying death is reviewed and is it mandated rather than advised that also any requests that do not follow up, is that …

Director of Health Policy:

The law allows for that to happen, but it does not say that has to happen in all cases. For example, if a person makes a first formal request for an assisted death and is found not to be resident in Jersey or to be aged 16 or whatever it is then that process stops, and we would not be looking to review those sorts of requests. I think Anna wanted to …

Policy Principal:

While that is not on the face of the law, it is likely - just what you were suggesting that in the first couple of years as the service becomes up and running - there will be more reviews to try and understand things like withdrawal of requests.

Deputy C.D. Curtis:

Okay, and will there be an external review and at what point of the process in the service?

Director of Health Policy:

An external review of the whole of the law or of the assisted dying service?

Deputy C.D. Curtis:

The assisted dying service, I think.

Director of Health Policy:

Okay, the Jersey Care Commission will independently inspect and regulate the assisted dying service. You have got the assurance committee who are responsible and have powers to take action around assisted dying practitioners. You have the review panel who review every single assisted death and then you have the Jersey Care Commission who will come in and do independent reviews of the assisted dying service and one of the things that the law does is it makes amendments to the Regulation of Care Law. Under the Regulation of Care Law, as drafted at the moment, the Jersey Care Commission cannot deregister a service where the Minister is the only provider of that service. Deregistration of a service effectively shuts it down but we are using the Assisted Dying Law to amend the Regulation of Care Law to say if the Jersey Care Commission has got concerns

about the safety of the assisted dying service, even though the Minister is the only provider of that service on the Island, they can deregister it, so they can shut it down.

Policy Principal:
There is a carveout just here.

Director of Health Policy:
Yes.

Deputy C.D. Curtis:
Okay, and will there be any surveys of practice, such as in the Netherlands, so perhaps family members or someone could contribute to a survey?

Director of Health Policy:
The law does not specifically mandate the fact that there are surveys of family members, but I have got absolutely no doubt that the assurance committee, which has to assure itself of the safety and the quality of the service, will be looking to speak to family members and loved ones about the process.

Deputy C.D. Curtis:
To get the feedback.

Director of Health Policy:
Yes, absolutely.

Deputy C.D. Curtis:
Who will provide advocacy services?

Director of Health Policy:
Assuming the States Assembly adopt the law in January, there will be an 18-month implementation phase and during that implementation phase, we will be developing some regulations that sit under the law. One of the regulations will provide for detail about the advocacy that will be provided to people who have requested an assisted dying, so who gets advocacy? What sort of advocacy do they get? What are the standards? What is the training and requirement of the advocate who is providing that advocacy? A little bit like under the Mental Health and Capacity Law, where there are specific regulations that relate to advocacy, there will be under this law as well. That detail has got to be worked out but the law requires the Minister to bring forward regulations that provide all those details.

Deputy C.D. Curtis:

Okay. Thank you.

Deputy L.M.C. Doublet:

Okay, we have 4 minutes and 3 remaining questions.

Deputy P.M. Bailhache:

Minister, one curious thing in the law which perhaps you could elucidate for us, Article 77 says: "The Minister must make every effort to establish and maintain an assisted dying service." We found the words "make every effort to" rather curious. I mean why not "must establish"?

The Minister for Health and Social Services:

I am not familiar as to why those particular words were chosen. If you can help me, Ruth. As I say, I am not familiar with why those particular words were selected.

Director of Health Policy:

The reason why those words are in there is there are circumstances in which the Minister may not be able to provide an assisted dying service. If the Minister is not able to recruit and identify a sufficient number of practitioners, people who choose to be an assisted dying practitioner, to safely deliver the service despite the Minister's best endeavours to do so, the Minister cannot stand up that service because that service must be safe. That is the reason why there is that rather strange wording. There is a requirement on the Minister to make every effort to do it, but we have recognised that there may be some circumstances beyond any Minister's control in terms of their ability to realise that.

Deputy P.M. Bailhache:

Okay. Final question and, again, a slightly legal question, perhaps, but the draft law provides that suicide is not an offence, which is fairly obvious, I would have thought, but it does say that there is an offence of aiding, abetting, counselling or procuring a person's suicide. Do you envisage any difficulty with that provision in relation to a person who assists somebody to take his own life under this law?

The Minister for Health and Social Services:

It has got to be very dependent on the circumstances that relate to that because if assisted dying is …

Policy Principal:

Not suicide.

The Minister for Health and Social Services:
… legal then it becomes quite difficult, does it not? It becomes a legal test, does it not?

Policy Principal:
What the law sets out is that assisted dying is not suicide.

Deputy P.M. Bailhache:
That is the reason for thinking that there is a clear distinction between assisting somebody to commit suicide and assisting somebody to have an assisted death.

Policy Principal:
There are a number of reasons why the policy principle of assisted dying not being labelled as suicide formed part of the consultation process but ultimately the effect of that is that the law is explicit in that assisted dying is not considered a suicide whereas there will be the creation of an offence with assisting someone's suicide. That would not impinge on anything that is done within the scope of this law.

Deputy L.M.C. Doublet:
Okay, do you have anything final?

Deputy C.D. Curtis:
No.

[14:00]

Deputy L.M.C. Doublet:
Anything to add, Deputy? Okay. Thank you very, very much for the answers to the questions today. I just wanted to note the weightiness of the topic that we have discussed today and, for anybody who may be watching online, if anybody has found it difficult, the Listening Lounge is available on 866793. Also just to thank you, Minister, and officers, everybody present, for the work that is going into this. It is very clear to me that the weightiness of this topic is being taken very seriously and the hard work that has gone into this is considerable, which is clear from the detail in the answers. Thank you for that. We will have a few questions that we would like to follow up in writing so we will get those to you as quickly as possible. Also, to thank our advisers. Professor Preston had to leave to chair another meeting, but I will send my thanks to her and thank you to the advisers for joining us today and for the questions. Do you want to add any final comments, Minister?

The Minister for Health and Social Services:

Yes, if I could reciprocate by thanking you for the in-depth nature of the questions and the quality of the approach to this. I very much thank the team here because, as I say, and I apologise to anybody listening if they are looking at me thinking: "Why have I not got all the answers?" You can see these good people have been working at this for a very long period of time and have got all the technical answers that are required and from my point of view it is just impossible to have that depth of knowledge. If I can apologise to the people if they think I am not doing my homework, there is just so much homework it would be impossible. Anyway, thank you.

Deputy L.M.C. Doublet:

Thank you for your time. Thank you, everyone, for attending and I will close the hearing now.

[14:01]