STATES OF JERSEY

DRAFT ASSISTED DYING (JERSEY) LAW 202- (P.65/2025): THIRD AMENDMENT

Lodged au Greffe on 10th February 2026
by the Assisted Dying Review Panel
Earliest date for debate: 24th February 2026

STATES GREFFE

DRAFT ASSISTED DYING (JERSEY) LAW 202- (P.65/2025): THIRD AMENDMENT

1 PAGE 137, ARTICLE 3 –

(1) Before Article 3(3)(a) insert –

(a) that, if they request assisted dying and their request is approved, the approved drugs are expected to be administered to the individual –

(i) by the individual themselves if they are physically able to do so (even if equipment or other support is required); or

(ii) by the administering practitioner otherwise;

(2) Renumber existing Article 3(3)(a) and (b) and cross-references accordingly.

2 PAGE 143, ARTICLE 8 –

(1) For Article 8(2)(b) substitute –

(b) the equipment and other support available to enable the individual to administer the approved drugs to themselves;

(2) For Article 8(2)(d) substitute –

(d) any risks of how the approved drugs are administered;

(3) In Article 8(2)(g)(i), after "assisted death" insert "if they lose consciousness after the initial administration of the approved drugs".

(4) Delete Article 8(4)(a)(ii).

(5) For Article 8(4)(b) substitute –

(b) that the approved drugs are expected to be administered to the individual –

(i) by the individual themselves if they are physically able to do so (even if equipment or other support is required); or

(ii) by the administering practitioner otherwise.

(6) Renumber Article 8(4)(a)(iii) and cross-references accordingly.

3 PAGE 146, ARTICLE 10 –

(1) After Article 10(1)(b) insert –

(c) may initially administer the approved drugs themselves only if the individual is not physically able to do so (even with the equipment and other support that is available); and

(2) Delete Article 10(1)(d).

(3) After Article 10(1) insert –

(2) If the individual's death does not result from the initial administration of the approved drugs in compliance with the care plan (so far as reasonably practicable), the administering practitioner may –

(a) in the circumstances described in paragraph (3) –

(i) arrange for the prescriber to change which approved drugs are prescribed for the assisted death under Article 34(2);

(ii) arrange for the administration of the approved drugs in a different way (such as swallowing or injection); or

(iii) arrange for the administration of more approved drugs;

(b) in the circumstances described in paragraph (3)(a) or (c), administer the approved drugs to the individual; or

(c) in the circumstances described in paragraph (3)(b) and in which the individual is not physically able to administer the approved drugs to themselves (even with the equipment and other support that is available), administer the approved drugs to the individual.

(4) In existing Article 10(2), for “This paragraph applies if” substitute “The circumstances are that”.

(5) For existing Article 10(2)(a) substitute –

(a) the individual has lost consciousness and has (at step 6) given consent to the continued carrying out of the assisted death if they lose consciousness after the initial administration of the approved drugs (at step 7);

(6) Renumber existing Article 10(1)(c) and (2) to (4) and cross-references accordingly.

4 PAGE 181, ARTICLE 78 –

(1) After Article 78(2) insert –

(3) The Service must, to the greatest extent that is reasonably practicable, provide all available equipment and other support to enable individuals to administer the approved drugs to themselves.

(2) Renumber existing Article 78(3) and (4) and cross-references accordingly.

ASSISTED DYING REVIEW PANEL

REPORT

[Self-administration generally required]

Introduction:

This proposed amendment, if adopted, would introduce a tiered framework for the administration model of the assisted dying service. The measure would introduce self-administration as the default model, with additional provisions for practitioner-assisted and practitioner-administered in cases of physical incapacity. The measure introduces a tiered approach to the administration model. Stage 1 guarantees that any eligible individual is enabled to self-administer the medication. Stage 2 would require the Minister for Health and Social Services to secure and provide all necessary resources to facilitate self-administration for individuals with reduced physical capacity. In stage 3, practitioner administration is permitted in circumstances where self-administration is unfeasible due to severe physical incapacity. The intended purpose of the amendment is to introduce a final safeguard against coercion and to ensure bodily autonomy at the final stage.

Evidence Considered:

The Panel considered the current proposed administration model, which currently allows for both self-administered and physician-administered assisted dying, "[1]*on the basis that restricting assisted dying to self-administration can significantly limit options for some individuals*".

During the Panel's Public Hearing with the Minister for Health and Social Services[2], the Panel asked about the administration model proposed in the draft Law, specifically the difference between assisted suicide and euthanasia and how that is relevant to the legislation. The Panel was informed that the available evidence indicates there are no universally agreed definitions for either assisted suicide or euthanasia; and that the proposed Jersey legislation provides for both practices. In relation to assisted suicide, understood in this context as physician-assisted suicide, the Panel was told this involves an administering practitioner supporting an individual to self-administer approved medication to end their life. In contrast, the Panel was informed that what is commonly described as euthanasia involves the administering practitioner administering the life-ending medication directly. Although the draft Jersey law does not explicitly use the term "euthanasia," the Panel was advised that its provisions have that effect. It was further informed that, in line with the P.18/2024 proposals, the draft Law permits both methods of assisted dying, with the choice between them resting with the individual.

The Expert Advisers ("the Advisers"), who were all in attendance at the Public Hearing, asked if the matter of whether practitioner-administered assisted dying should be limited to individuals who are physically unable to self-administer life-ending medication had been considered during the earlier stages of policy development. They were advised that this issue was explored during the consultation process conducted after the first States debate and prior to the current Minister taking office.

The Panel was told that the consultation process, drawing on feedback from both the public and healthcare professionals, shaped the policy direction. The Minister emphasised that the approach taken has been evidence-based. Government Officials explained that an ethical review commissioned by the former Minister for Health and Social Services examined the distinctions between assisted suicide and euthanasia, and that the findings were subsequently considered by the previous Council of Ministers.

The Panel was advised that, following this review, the previous Minister and Council collectively agreed to progress proposals allowing for both assisted suicide and practitioner-administered

[1] P-18-2024.pdf
[2] 2025-11-19-Transcript-MHSS-(1).pdf

assisted dying. These proposals were then presented to the States Assembly, which endorsed the development of legislation providing for both methods. The Panel was informed that the process had been transparent throughout and that the issues involved have been under continuous, active consideration.

The Panel further asked the Minister for Health and Social Services whether his policy intention would still be met if the administration model was limited to self-administration unless someone could not physically self-administer themselves. The Panel heard that the Minister did not believe this would align with what consultation and further feedback has demonstrated regarding views of the public. The Minister did not agree with the notion of:

> "*restricting the rights of a personal who wants to end their own life to choose the way in which they would like to end their life…, if consultation is delivered that that is what the public want, I would certainly want to meet those needs.*[3]"

The Panel also asked whether the purpose of retaining the administration model was to allow individuals the option of either self-administration or practitioner-administration. The Minister confirmed that this was indeed the rationale.

The Panel highlighted that the proposed administration model enabled further safeguarding risks in terms of coercion than a model that ensures self-administrations unless circumstances prevented it. It was further clarified that during the policy development work, there was consideration of options including an administration model reflecting that which the Panel is proposing. However, such a model was rejected due to the consultation with healthcare professionals who informed the Minister that there were concerns regarding medical professionals facing uncertainty as to how they should operate within the legislation.

In developing its amendment, the Panel has taken into account evidence received, including from its Advisers, who observed within their report that the Ethical Review[4] undertaken in 2023 considered the ethical issues associated with self-administration and practitioner-administration of assisted dying. It was advised that credible arguments exist both for and against each approach. The Ethical Review noted that, if the States Assembly judges these arguments to be broadly balanced, it may consider allowing both modes in order to support patient autonomy. However, the Review also noted that the Assembly might prefer to make self-administration the primary route, limiting practitioner-administration to exceptional cases. Concerns associated with practitioner-administration included increased use of this administration model over time in other jurisdictions, potential implications for healthcare professionals, and evidence that fewer people withdraw from proceeding when practitioners are responsible for administering the drugs. The Ethical Review therefore suggested that self-administration may be the more cautious option, while still recognising the need for practitioner-administration where individuals are unable to self-administer.

Finally, the Panel was advised that, should self-administration be permitted, international experience indicates that the choice of drugs and methods would require careful evaluation to ensure safety and effectiveness.

Other Jurisdictions

The Advisers' report further noted, that, under the law in Victoria, Australia, practitioner-administered assisted dying is permitted only where an individual is physically unable to self-administer the medication. The report informed the Panel that, in 2024–25, 492 permits were issued for self-administration compared with 142 permits for

[3] 2025-11-19-Transcript-MHSS-(1).pdf – Page 14
[4] Assisted Dying in Jersey Ethical Review Report.pdf

practitioner-administration. The Advisers indicated that this disparity likely reflects the fact that practitioner-administration is strictly limited to cases where self-administration is not possible, resulting in the majority of individuals relying on self-administration as the primary mode. The Advisers' report highlighted that this approach was considered during the development of Jersey's proposals but was not adopted, following feedback from healthcare professionals who expressed concern about the practical challenges of defining when a person is "physically unable" to self-administer. However, the report noted that there is no evidence from Victoria to suggest that clinicians experience systemic difficulty in determining whether a patient is unable to take or digest the approved medication.

The Panel was further informed that Article 10(3) of Jersey's draft Law already allows a family member or friend to assist an individual with self-administration, for example, by helping them raise the medication to their mouth. It was noted that, if Jersey were to adopt a model similar to Victoria's, this provision would enable individuals to self-administer wherever physically possible, with or without assistance, while practitioner-administration would be reserved for situations where self-administration cannot be safely achieved. The Panel was advised that this structure would align with several reasons identified by the Citizens' Jury[5] in support of offering practitioner-administration only as a secondary option.

The Panel was informed by the Advisers that according to anecdotal evidence in Switzerland, where only self-administration is permitted, adapted methods could be included, such as using a cushion which the patient presses with their chin for self-administration in cases where the patient can no longer use their hands. It is noted, however, that the intravenous (IV) method is more commonly used. The Panel considered the use of adapted methods and equipment to support self-administration. The Panel also noted that a key distinction in jurisdictions such as the United States and Switzerland is that healthcare professionals are not present during self-administration, unlike the arrangements proposed for Jersey.

Consideration of '*physically unable*' and '*psychologically unable*'

In developing its amendment, the Panel considered the distinction between a person being *physically unable* to self-administer and a person being *psychologically or emotionally unable* to self-administer. In particular, the Panel examined the implications of removing the word "*physically*" from the draft provision and held an extensive discussion on the significance and purpose of this term.

The Panel explored scenarios in which an individual may be deemed physically capable of self-administration but, due to psychological or emotional distress, feels unable to do so. In doing so, the Panel assessed the practical and legal consequences of broadening the provision to include non-physical reasons for being unable to self-administer.

Concerns were raised by the Panel that removing the term "*physically*" could create ambiguity and leave the provision open to interpretation. The Panel noted that this could, in practice, result in practitioner administration being used more frequently and potentially becoming the default model, contrary to the Panel's stated intention. The Panel maintained its position that self-administration should remain the default model for assisted dying, with practitioner administration reserved for exceptional circumstances only.

As part of its considerations, the Panel also examined whether jurisdictions that use self-administration as the default model, with practitioner administration permitted only in exceptional circumstances, include reference to "physical" ability within their legislation. The Panel noted that the Victoria model in Australia does explicitly use the term "*physically*", reinforcing the distinction between physical incapacity and other forms of inability[6].

[5] Should Assisted Dying be Permitted in Jersey, and If So, Under What Circumstances? Final Report from Jersey Assisted Dying Citizens' Jury', p.55
[6] Voluntary Assisted Dying Act 2017, Victoria, p.40

The Panel also considered the implications for medical practitioners. For instance, if an individual were physically able to self-administer but declined to do so due to emotional distress, this could place practitioners in an ethically challenging position. The Panel recognised the potential impact of this on practitioners' willingness to participate and on their professional wellbeing. Following detailed discussion, the Panel concluded that removing the term "*physically*" would alter the underlying principle of the amendment. The Panel had sought to strengthen safeguarding provisions, with self-administration acting as a final safeguard within the proposed framework. The Panel therefore agreed that retaining the term "*physically*" was necessary to preserve the intended safeguards and the balance of responsibilities within the model.

The Panel considers that this approach supports safeguarding against coercion, without impeding bodily autonomy. Self-administration can be viewed as the approach that most directly upholds bodily autonomy because it ensures that the final act remains entirely under the control of the individual themselves. Autonomy, in this context, is grounded in the principle that a person should have ultimate agency over decisions affecting their own body and life. By requiring that the individual performs the final step, self-administration provides the clearest possible evidence that the decision is voluntary, contemporaneous, and personally enacted. In contrast, practitioner administration introduces a degree of dependency on a third party and requires the individual to transfer responsibility for the final act to a clinician, which may dilute the direct expression of personal control.

The Panel therefore considers that the self-administration model as the default model introduces a stronger safeguard against coercion. The individual must take an active step that cannot be performed on their behalf, reducing the risk of subtle pressure or influence from others. Practitioner administration, even with appropriate safeguards in place, transfers the final act to a clinical setting and introduces a level of practitioner involvement that may, however inadvertently, blur the distinction between supporting an individual's decision and carrying it out on their behalf. This risk becomes more pronounced in situations where the individual is vulnerable to coercion.

Furthermore, the Panel considers that self-administration can enhance a person's sense of dignity and ownership over the process. The Panel considers that the self-administration model enables individuals to choose the moment, the context, and the circumstances in which they act, reinforcing their agency. Practitioner administration, by contrast, typically requires more structured, clinical involvement, which may limit flexibility or impose conditions that constrain personal choice.

Rationale

For these reasons, the Panel has concluded that making self-administration the default model and permitting practitioner administration only in cases of genuine physical incapacity, strikes an appropriate balance between autonomy, safety, and compassion. The Panel's amendment therefore introduces a requirement on the Minister to ensure all equipment and support mechanisms are available to the individual to carry out the self-administration, while reserving practitioner-administration to exceptional cases where a person lacks the physical ability to carry out self-administration, even with adapted equipment. This approach preserves the individual's control where possible, while still ensuring that no person is excluded from accessing assisted dying solely because their physical condition prevents them from carrying out the act themselves.

Conclusion

In bringing forward this amendment, the Panel has sought to ensure that the Draft Assisted Dying Law incorporates a final and robust protection against coercion within the administration model. Having examined the evidence presented by expert advisers, reviewed international legislative frameworks, and considered the ethical analysis undertaken during previous stages of policy

development, the Panel has concluded that establishing self-administration as the default method offers the strongest safeguard while maintaining respect for individual autonomy.

The Panel recognises that the draft Law, as currently proposed, allows individuals to choose between self-administration and practitioner administration. However, the evidence reviewed demonstrates that practitioner administration carries a higher inherent risk of blurring the boundary between supporting an individual's decision and performing the final act on their behalf, particularly where a person may be vulnerable to coercion. By contrast, self-administration requires the individual to take the final step themselves, providing the clearest assurance that the act is voluntary, conscious, and free from coercion. The Panel acknowledges that, as with any new system, the introduction of assisted dying service may involve errors or unintended consequences. This model therefore enhances safety, security and public confidence by placing greater safeguards around the final act and ensuring that the process remains as controlled and protective as possible.

The Panel's amendment therefore introduces a staged framework in which self-administration is the default route, and practitioner administration is permitted only where an individual is physically unable to self-administer, even with assistance or adapted equipment. This model reflects cautious, evidence-based practice observed in other jurisdictions, including Victoria, Australia, and aligns with conclusions reached in the 2023 Ethical Review, which identified self-administration as the more *conservative and protective option*, while recognising that practitioner administration remains necessary in a limited number of cases.

To ensure that self-administration is feasible for all eligible individuals, the amendment places a requirement on the Minister for Health and Social Services to secure and provide the necessary equipment, adaptations, and support mechanisms to facilitate self-administration wherever possible. This ensures that no person is excluded from accessing assisted dying solely because of physical limitations, while maintaining clear and narrow criteria for practitioner involvement.

The Panel considers that this approach strikes the appropriate balance between autonomy, safety, and compassion. It preserves individual control where possible, strengthens safeguards against coercion, and ensures that practitioner administration operates only as a route for those who cannot physically undertake the act themselves.

Financial and staffing implications

The Panel does not anticipate any additional cost from this amendment. However, the Panel notes that the resources and materials required to necessitate self-administration will incur a cost.

Children's Rights Impact Assessment

The Panel considers that this proposition (amendment) has no direct or indirect impact on children and that he duty to have due regard to the UN Convention on the Rights of the Child does not arise. Accordingly, a Children's Rights Impact Assessment is not required under the Children (Convention Rights) (Jersey) Law 2022.