STATES OF JERSEY

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

Lodged au Greffe on 5th January 2026
by Deputy B. Ward of St. Clement
Earliest date for debate: 20th January 2026

STATES GREFFE

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

1 PAGE 143, ARTICLE 8 –

(1) Delete Article 8(2)(g)(ii).

(2) Delete Article 8(5) to (7).

(3) Renumber Article 8(2)(g)(iii), (8) and (9) and cross-references accordingly.

2 PAGE 144, ARTICLE 9 –

(1) Delete Article 9(1)(k).

(2) For Article 9(2)(c)(i) substitute –

> (i) it is appropriate to carry out the assisted death if the practitioner is satisfied that the individual has that capacity and reasonably believes that the final request is voluntary; or

3 PAGE 146, ARTICLE 10 –

Delete Article 10(2)(c).

4 PAGE 149, ARTICLE 17 –

(1) Delete Article 17(4).

(2) Renumber Article 17(5) to (8) and cross-references accordingly.

5 PAGE 153, ARTICLE 23 –

In Article 23(1)(c), delete "6 or".

6 PAGE 155, ARTICLE 26 –

In Article 26(1)(c), delete "6 or" and "8(2)(a) or".

7 PAGE 155, ARTICLE 27 –

In Article 27(6), delete "6 or" and "8(2)(a) or".

8 PAGE 165, ARTICLE 42 –

In Article 42(2)(d), delete "8(6)(a) or" and "6 or".

DEPUTY B. WARD OF ST. CLEMENT

REPORT

This amendment relates to the 'Waiver of requirement for future capacity' (the "Waiver") as detailed fully on page 22, part 95 of the Report to the Draft Assisted Dying (Jersey) Law 202- (the "Draft Law").

> *95. Waiver of requirement for future capacity*
>
> *a. The draft law provides that, at step 6, the individual may choose to waive the requirement for them to have future capacity.*
>
> *b. The waiver allows the individual to decide in advance that, if they lose decision making capacity AFTER their request for an assisted death has been approved (Step 5) but BEFORE they are due to confirm their consent during the final review (at Step 7), the assisted death can still take place. The rationale for the waiver is ensure that a person whose capacity deteriorates rapidly is not prevented from having their request fulfilled in accordance with previously agreed arrangements.*

This amendment seeks the removal of the Waiver from the Draft Law as presented.

The addition of the Waiver changes the fundamental principle of the Draft Law, which throughout emphasises that the patient has capacity at the point of the assisted death by way of self-administration or with agreement at the time via an injection. It is my view that to include the Waiver changes the Draft Law from an Assisted dying action to an administering practice of Non-Voluntary Euthanasia, which is the act of deliberately ending a person's life to relieve suffering. Presently voluntary or non-voluntary euthanasia is regarded as either manslaughter or murder which can attract a prison sentence.

To further explain the reasons for the removal of the Waiver.

1. **The Waiver**: this is an advance direction to abandon the right to having capacity and to consent to the assisted death. This is remarkable and could be considered to breach a wide range of ethics, practice and law, including the Capacity and Self Determination (Jersey) Law 2016 (the "Capacity Law").

   It is also illogical for two reasons:

   - if a person is unconscious or deteriorating rapidly, they are either no longer distressed, and in pain or if not can have their distress and pain easily managed with therapeutic treatments with legally prescribed medication (as opposed to an administration of lethal drugs); and
   - a person, who demonstrates with cognitive impairment could be given an assisted death despite being settled and comfortable. This raises the question of whether there are sufficient safeguarding measures? Is there a greater risk of coercion from family members who may have motives other than the best interests of the patient.

2. **Self-Administration**: experience from other jurisdictions that have both self-administration and practitioner administration shows that most assisted deaths are practitioner administered. Therefore, the current draft will allow waivers of consent that will inevitably be followed by a practitioner administered lethal dose.
3. **Deemed Capacity**: neither Jersey nor Westminster capacity laws were intended to cover assisted death requests since they both include a presumption of capacity and do not require coercion to be considered. Assisted death requests require a much higher bar.

The proposal for a waiver of future capacity directly conflicts with the safeguards claimed in the Draft Law. The above issues, combined with isolated doctor or administrating practitioner assessments that are not monitored or require consultation, are a recipe for bias to seep in, and for discrimination, possible negligence, coercion and even criminality to go unchecked.

Administration of approved drugs

The Waiver is described at step 6 of the Draft Law –

> *(5) At step 6, an individual may also, by telling the administering practitioner, make their final request for assisted dying and propose to waive the requirement for future capacity (in case they later lose capacity).*

Such Waiver therefore provides the administering practitioner permission to administer the approved drugs if the patient is unconscious or has lost capacity on the agreed date for the assisted death. It is my belief that to administer terminal drugs to an unconscious patient is NOT an assisted death but an act of euthanasia or a form of manslaughter. My view is that the patient has not been afforded their right to 'change their mind'.

Data from jurisdictions where euthanasia or medically assisted suicide have been legalised is patchy and incomplete. The report to the Draft Law even cites (on page 19) that in Western Australia in 2022 around 28% of people who were approved for an assisted death did not go on to have an assisted death. This is a high percentage of patients and should not be passed over or ignored.

The phrase 'it's in the patients "Best interests" ', is probably the most abused phrase in clinical care but has a clear definition in capacity legislation. Unfortunately, clinicians often do not understand the legal requirements to assess 'best interests' and more work and training needs to be conducted on this aspect.

Many clinicians would agree with the Swiss Academy of Medical Sciences that assisted dying is **NOT** a treatment:

- Assisted suicide is not a medical action to which patients could claim to be entitled, even if it is a legally permissible activity. This has been the case for some 80 years in Switzerland where assisted dying takes place almost entirely outside of public healthcare.
- This view conflicts directly with assisted dying campaigners who are adamant that it is a treatment, in which case one cannot make an advance decision to demand it; one is only entitled to make a legally binding decision to refuse it.

A waiver of capacity and consent goes against these legal precedents.

The Draft Law as presented at many public and political briefings emphasises that the patient must be competent and have capacity at the point of self-administrating or (in agreement with their administering practitioner as the patient may not be able to swallow) of the administration of terminal drugs.

Advanced Decision making

It is interesting, that Jersey's Citizens' Jury back in September 2021 were not asked about the terminology we now see as set out in this draft Law 'Waiver of final consent' at stage 6. They

were asked about 'Advanced decision-making', which is quite different to making a waiver. The two aspects are not the same.

The issue about Advance Decisions (or Directives) in relation to medical treatment, in Jersey and in England and Wales, is that they are only legally binding if the patient ***refuses*** treatment and active interventions, in which case they are valid (provided the procedure is correctly completed) and appropriate to the situation. UK Courts have rejected the principle of demanding a future treatment on several occasions (usually related to Cardiopulmonary Resuscitation (CPR)). The reasoning and opinion given is that an individual could not anticipate the circumstances in which the treatment demand was to be enacted. Therefore, such an advance decision to request a treatment could not be binding on clinicians.

The Citizen's July showed support for an Advanced Directive when the person had capacity but caveated their support for instances when the person had lost capacity to 'certain circumstances'. However as stated the use of an advanced directive is clear in its definition it is about the ***refusal*** of an intervention and is not appropriate in an Assisted dying law.

The signing of a Waiver, in my view, brings into question ethical and moral issues – principally: 'Is it right to inject an unconscious patient with a lethal injection?' The unconscious patient is not in pain or anxious, they are clearly at peace, near the end of their life, and will continue to be cared for palliatively with love, kindness and only if appropriate with full medical approval be prescribed and administered approved legal medications to address any pain or suffering.

Patients who do not sign a waiver and fall into an unconscious state or lose capacity are also cared for palliatively with love, kindness and only if appropriate with full medical approval be prescribed and administered approved legal medications to address any pain or suffering.

Coercion and capacity

It should be noted that the administering practitioner can decline the intervention if it is felt the unconscious or incapacitated patient appears to be rejecting the action. However, there remains the possibility of coercive approaches from family onlookers trying to push a practitioner to administer the terminal medication – a scenario that brings into question whether safeguarding would be sufficient to ensure that administering practitioners were not influenced.

My view is that the patient must have capacity and demonstrate clear agreement to have their assisted death **at all stages** –

- The Waiver could be made at a time when the patient is taking some powerful legally prescribed medications, which we know do sometimes interfere with the patient's cognitive processes and capacity, in other circumstances they would not be deemed competent to make serious life changing decisions e.g. making a will etc.
- This amendment is not about interfering with a person's desire to access an assisted death, but they must be competent to say Yes or No for the death to proceed on the agreed day and time. The Waiver changes this from assisted dying to involuntary euthanasia.
- We need to understand and be very clear that the provision of terminal drugs is NOT a treatment.

A psychiatrist needs to be involved at an early stage if a person expresses a wish, whether that be absolute or just a possible option, for euthanasia or medically assisted suicide because they are best placed to conduct a thorough psycho-social assessment. Of course, that raises the question of whether mental health services and specifically the on-island medical psychiatric workforce could provide this in Jersey. Indeed, whether a psychiatrist would be willing to do this? This is a significant implementation issue (or would be if psychiatric assessment was to be made mandatory) and makes implementation impracticable.

In England the Terminally Ill Adults (End of Life) Bill, is currently in committee stage in the House of Lords: Clause (25) subsection (5) sets out that –

> *The coordinating doctor must be satisfied, at the time the approved substance is provided, that the person to whom it is provided –*
>
> *(a) has capacity to make the decision to end their own life,*
>
> *(b) has a clear, settled and informed wish to end their own life, and*
>
> *(c) is requesting provision of that assistance voluntarily and has not been coerced or pressured by any other person into doing so.*

Subsections (7) and (8) of Clause (25) make it clear that the decision to self-administer the approved substance and the final act of doing so, must be taken by the person themself and not by the co-ordinating doctor. Thus, in the UK Bill there is no waiver for those who have lost capacity between giving consent and the time of the administration of the lethal drugs.

I believe that the Jersey Law should be in line with the English version and require that all patients to fulfil the statutory criteria as in England, ensuring that the person has legal capacity at all stages of the process especially at the point of self-administration or via the administrating practitioner of the drugs due to a person with swallowing difficulties.

Stating the obvious, if someone has lost capacity then it will not be possible to establish their consent at that time, therefore the administrating practitioner will be unable to go ahead with the administration of terminal drugs.

Conclusion

The Waiver and the safeguarding stipulations are not compatible – indeed I consider that they are in opposition to each other. The inclusion of the waiver opens opportunities for misinterpretation, manipulation and possible abuse and coercion.

I do not support the inclusion of a waiver in the Jersey Law, but should this be one be agreed then it is essential that a clear Yes/No answer has been established, when the patient has mental capacity, to the question of Intra Venus (IV) drug administration of the lethal drug in the event that the oral drugs do not bring about death. **And** that a second Yes/No question has been established as to whether or not they would wish for IV drug administration to proceed if they had lost capacity i.e. two very specific binary questions.

The assessment of capacity is not straightforward – capacity may fluctuate over short periods of time even hours, and is dependent on the assessor's experience and values.

The Capacity Law was not anticipated to be used to assess capacity to end one's life – especially since only a single assessor is required at stage 6.

In England and Wales, the Mental Capacity Act became law in 2005, 11 years before the Capacity Law. Despite this and the early implementation of mandatory training in capacity assessment there is still unease in England and Wales about whether it is really fit for purpose. Questions raised include –

- whether the level of training required is sufficient for such a complex task;
- whether 2 independent assessments would be safer particularly for life-changing decisions at all stages; and
- whether it should be mandatory that a psychiatric assessment is also made or that a psychiatrist is one of the assessors at all stages.

In Jersey, that level of unease should be much greater due to the ongoing issues with recruitment and retention of health and social care staff, including those working in mental health services. Furthermore, the fact that mandatory training in assessment of mental capacity is not well established in Jersey should heighten concerns.

The numerous questions raised in this amendment demonstrate the unsatisfactory nature of including a Waiver in the Draft Law and highlight that this should be removed.

People who wish to have an assisted death via self-administration need to be supported.

But there should be no intervention where a patient becomes unconscious or has lost capacity and is unable to say Yay or Nay. They need to be cared for compassionately, and with kindness, through a palliative approach receiving required medication to ensure no suffering as they near the end of their journey.

Financial and staffing implications

There are no further financial or staffing implications other than those already identified within the Draft Law.

Children's Rights Impact Assessment

I consider that this amendment has no direct or indirect impact on children and that the 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.