STATES OF JERSEY

DRAFT ASSISTED DYING (JERSEY) LAW 202-

Lodged au Greffe on 2nd September 2025
by the Council of Ministers
Earliest date for debate: 21st October 2025

STATES GREFFE

Jersey

DRAFT ASSISTED DYING (JERSEY) LAW 202-

European Convention on Human Rights

In accordance with the provisions of Article 16 of the Human Rights (Jersey) Law 2000, the Minister for Health and Social Services has made the following statement –

In the view of the Minister for Health and Social Services, the provisions of the Draft Assisted Dying (Jersey) Law 202- are compatible with the Convention Rights.

Signed: **Deputy T.J.A. Binet of St. Saviour**

Minister for Health and Social Services

Dated: 29th August 2025

REPORT

Section 1: Background

This section of the report provides background information, outlines the process for developing the draft law and details planned activity during the lodging period.

Background

1. On 22 May 2024, the States Assembly ("the Assembly") voted for the Council of Ministers' proposition P.18/2024 requesting the Minister for Health and Social Services ("the Minister") to:[1]
   a. bring forward primary legislation that permits assisted dying in Jersey for those with a terminal illness and a life expectancy of 6 months, or 12 months for those with a neurodegenerative condition (referred to as 'Route 1' in P.18/2024)
   b. establish an assisted dying service in accordance with essential provisions and safeguards set out in that proposition

2. In adopting P.18/2024, the Assembly rejected proposals to permit assisted dying for people who have an incurable physical condition but where there is no reasonable expectation of death within a short timeframe (referred to as 'Route 2' in P.18/2024).

3. Following the Assembly's decision, work was undertaken to develop law drafting instructions that accords with the detailed proposals set out in P.18/2024. Those instructions were issued by the Minister on 15 November 2024.[2]

4. A health and care professionals working group was established in September 2024 to support the development of the draft law and prepare for the implementation of an assisted dying service. That working group was in addition to the Professional Leads Group who provided senior clinical oversight throughout the development of the P.18/2024 proposals.[3]

5. The working group provides the perspective of professionals who work across the areas of health care practice likely to be impacted by the introduction of an assisted dying service. Members include representatives of non-Government health and care organisations in addition to Health and Care Jersey ("HCJ") staff [4].

6. During the legislation development phase there has also been ongoing engagement with key stakeholders, including:
   a. Jersey Care Commission

[1] States Assembly | P.18/2024
[2] Assisted Dying: Law drafting instructions
[3] Assisted dying in Jersey [see section on 'Professional Leads Working Group']
[4] Assisted-dying-working-group-terms-of-reference.pdf

b. UK professional regulatory bodies[5]
c. Professional leads working group[6]

7. The UK professional regulatory bodies provided feedback (either via written response or by feedback meeting) on aspects of the draft law that impacts their registrants. These responses included feedback on the provisions related to the right to refuse to participate; the registration of assisted dying practitioners; and the requirement on the Committee to develop operational guidance.

8. Officers have also worked to keep the Assisted Dying Review Panel updated during the law drafting process.[7]

9. In agreeing P.18/2024, the Assembly agreed, in principle, the provisions and effects of the draft law, which were shaped by two phases of extensive public and stakeholder engagement undertaken in 2022 and 2023, in addition to the Assisted Dying Citizens Jury[8] [9] [10]. For this reason, further public engagement has not been undertaken during the law drafting phase. See Appendix 1 for detail on the development of proposals prior to P.18/2024.

10. The draft Law accords with the P.18/2024 proposals agreed by the Assembly, subject to a few minor refinements and updates identified during the law drafting process. These are referenced in the relevant sections of this report and include the following:

Updates to P.18/2024	**Paragraph number**
Independent Assessment Doctor may view the first assessment form	67
Independent Assessment Doctor must declare interests in respect of Coordinating Doctor	155
Request for second opinion assessment	189
Update to process for responding to complaints	191
Waiver of final confirmation of consent / future capacity clarifications	95
'Step transition' renamed 'request to proceed'	127
Update to administration witness	100

[5] The UK Professional Regulatory Bodies include General Medical Council (GMC); Nursing and Midwifery Council (NMC); Health and Care Professions Council (HCPC); General Pharmaceutical Council (GPhC) and Social Work England (SWE). In addition, the British Medical Association (BMA) has continued to engage with the development of the proposals
[6] Assisted dying in Jersey [see section on 'Professional Leads Working Group']
[7] States Assembly | Assisted Dying Review Panel
[8] Public engagement summary report on assisted dying in Jersey
[9] Assisted dying in Jersey consultation
[10] Citizens' Jury on assisted dying in Jersey

Update to location of meetings & additional assessments/relevant opinions	141
Assessing doctor must tell the individual if they disagree with individual's belief about suffering / anticipated suffering	166
Appeals to health criteria	238
Reporting on protected characteristics	270
Regulations to provide for independent advocacy	158
Regulations to require an individual to pay a fee	284

End-of-life care

11. P.18/2024 made two key statements in relation to the provision of end-of-life care:

    a. *consideration will be given to placing a statutory duty on the Minister for Health and Social Services to provide palliative care and end of life care as part of proposed Adult Safeguarding Law that is currently in development*

    b. *the assisted dying should not be brought into force until the Assembly is satisfied that decision taken in the 2023 Government Plan to provide for additional investment in end of life and palliative care is supporting improvements in quality and availability of those services*

12. With regard to the statutory duty (as per sub-paragraph a. above), work on the proposed Adults Safeguarding Law has been delayed due to competing priorities. Hence, consideration has been given to other routes for bringing forward that duty.

13. It was initially proposed that this could be achieved via a regulation making power under the assisted dying law, however, this option creates significant difficulties in that the assisted dying law would effectively be recast as an assisted dying and end-of-life care law. "Co-joining" assisted dying and end-of-life care in a single piece of legislation is not considered appropriate.

14. The Minister, recognising the importance of bringing forward a statutory duty related to end-of-life care, will lodge a separate proposition before end of September 2025, to ask the Assembly to agree that a new end-of-life care law should be presented to Assembly before the assisted dying law, if adopted, comes into force. It is anticipated the assisted dying law will not come into force until around 18-months post adoption of that law (c. late Summer 2027).

15. The Minister is lodging a separate proposition because it is understood that it would be procedurally difficult for the Assembly to determine two separate matters in a single proposition (i.e., the adoption of the assisted dying law alongside the bringing forward of an end-of-life services law).

16. With regard to improvements in end-of-life care (as per sub-paragraph b. above), the Minister will be lodging an addendum to this report and proposition which will include evidence of improvements of quality and availability of palliative and end of life care in Jersey. This accords with Scrutiny recommendations (as described below).

Addendum

17. The Scrutiny Review Panel established to examine proposals for assisted dying, as set out in P.18/2024, made several recommendations in their review report.[11] These recommendations included placing a requirement of the Minister to publish additional information about the planned implementation of an assisted dying service, and to do so no later than 2 months before the draft law is scheduled for debate.

18. In accordance with the Panel's recommendations, an addendum to this report will shortly be published providing the information requested in response to the following Scrutiny recommendations:

Scrutiny recommendation number and theme		
1*	End of life care	The Minister for Health and Social Services should publish a plan to evidence the quality and availability of palliative and end of life care in Jersey.
2	End of life care	The Minister for Health and Social Services should confirm the timeline for the development of a Palliative and End of Life Care Strategy beyond 2026.
2*	Training & guidance	Minister for Health and Social Services should publish an appendix to the final proposals for assisted dying, setting out the training requirements, that comprehensively cover the identification of and prevention of coercion.
6	Training & guidance	The Minister for Health and Social Services should publish the full details and processes for establishing refusal or resistance to an assisted death for a person who has lost decision-making capacity.
10	Training & guidance	The Minister should publish details and plans about assisted dying training and guidance that include: • A detailed summary outlining all items of assisted dying guidance to be developed and produced. • The items of guidance to be prioritised, shared and presented to States Members. • Details and plans about the development of the assisted dying training programme
7	Location of assisted deaths	The Minister for Health and Social Services must provide details about the timeline and stakeholders involved in discussions regarding appropriate places within the Jersey General Hospital for assisted dying.

[11] States Assembly | Report - Review of Assisted Dying - 14 May 2024

9	Location of assisted deaths	The Minister for Health and Social Services must ensure robust planning is in place to mitigate the potential impact of assisted dying on any other residents or patients of Government of Jersey owned and / or managed care and nursing facilities.
11	Staff & recruitment	The Minister for Health and Social Services should provide details about how general recruitment and staffing challenges across the Health and Community Services Department will be addressed in relation to the additional resource implications associated with the Assisted Dying Service.
12	Staff & recruitment	The Minister for Health and Social Services should provide details and plans to mitigate and respond to the risk of Health and Community Services not being able to recruit sufficient staff to the Assisted Dying Service.

*indicates a key recommendation of the Scrutiny Panel

Lodging period

19. The standard minimum lodging period for a proposition brought forward by the Council of Ministers is 6 weeks. Given the importance and complexity of the draft law, an extended lodging period has been agreed to provide time for the public, health and care professionals, and States Members to engage with the draft law. It is expected that the draft law will be debated before end 2025. The following activities will be undertaken during the lodging period. Further details are provided at gov.je/assisteddying

Lodging period activity

Public

- minimum of 4 public information sessions in different locations
- dedicated sessions for disabled Islanders, working with Enable to ensure specialist communication support is provided, as required
- www.gov.je/assisteddying to be updated to include:
  - a summary of the key provisions of draft law
  - updated 'case studies' to illustrate how key safeguards will work
  - Q+A section – to be updated to incorporate questions/concerns raised during public sessions

Health and care professionals

- dedicated information sessions for health and care professionals (these will be post-work or evening sessions to best accommodate staff availability)
- meetings with local health and care providers, as requested

States members briefing:

- 3 x States Members briefing sessions
- Fortnightly 'drop in' sessions, for Members to discuss the draft law on a 1-to-1 basis

Section 2: Part 1 of draft Law – definitions and criteria

20. Part 1 of the draft law defines key terms used in the law and sets out the eligibility criteria for assisted dying.

Overview of defined roles

21. Amongst other matters, Article 1 defines the roles of professionals who opt in to work for the Assisted Dying Service ("the Service") [see section 4 (paragraphs 285 to 294) for more detail on registration of professionals, and paragraphs 209 to 217 for detail on right to refuse to participate in assisted dying and protections for professionals].

22. **Care Navigator** - A non-clinical staff member who will support the individual requesting an assisted death and support the Coordinating Doctor to coordinate the process. The initial point of contact for information and enquiries into the Assisted Dying Service. The Care Navigator must complete the mandatory assisted dying training, but they do not need to be registered with the Assisted Dying Service because they are not clinical staff.

23. **Certifying Doctor** – the doctor who certifies an individual's assisted death**.** They need to be registered with the Assisted Dying Service and must have undertaken the mandatory assisted dying training.

24. **assisted dying practitioner** – the general term used to describe any health professional who is registered with the Assisted Dying Service, having met all registration requirements including mandatory training. This includes:
    a. assessing doctors (i.e. Coordinating Doctor, Independent Assessment Doctor, Second Opinion Doctor)
    b. Administering Practitioners
    c. Pharmacy Professionals
    d. extended team members.

Involvement in assessment & approval process

25. **assessing doctor** – the general term used to describe any doctor involved in the assessment process. This could include a Coordinating Doctor, an Independent Assessment Doctor or a Second Opinion Doctor.

26. **Coordinating Doctor** – the specific term used for the doctor who receives the individual's first and second request (at step 1 and step 4), undertakes the first assessment of the individual (at step 2), coordinates the whole assessment process, and makes the decision to approve or refuse the individual's assisted dying request (at step 5).

27. **Independent Assessment Doctor** – the specific term used for the doctor who undertakes the independent assessment of the individual (step 3).

28. **Second Opinion Doctor** - the doctor who may undertake a second opinion assessment if the individual requests a second opinion assessment, whether after the first (step 2) or independent assessment (step 3), and that request is accepted by a "review doctor" – see Articles 32 and 33 of draft law.

29. **Extended team member** – an extended team member may include, for example, a registered nurse, social worker or any relevant allied health professionals (e.g., a speech and language therapist, physiotherapist or dietician). An extended team will be formed to support the assessment process for individuals who request an assisted death. The purpose of the extended team is to provide check and challenge for the assessing doctors and a multidisciplinary perspective to discussions of eligibility.

Extended teams are commonly referred to as multidisciplinary teams ("MDT") in healthcare practice. The term MDT was used in P.18/2024.

30. **Extended team working practice**

a. In accordance with P.18/2024, the draft law does not prescribe matters related to the requirement for an extended team, its membership or practice as these will vary depending on the needs and circumstances of each individual who requests an assisted death. For example, an extended team:
   - may not be required where an individual does not meet the residency criteria (although an individual social worker or counsellor may to be required to provide the individual with support to process refusal of their request)
   - may not require involvement of speech and language therapist if the individual does not require speech and language support.

b. The draft law does, however, provide that:
   - the extended team members are registered assisted dying practitioners who met the required competencies and have undertaken the relevant mandatory assisted dying training
   - extended team members may provide professional opinions (Article 31)
   - the Committee must bring forward operational guidance on assessing individuals for assisted dying and care planning (Article 62) and the guidance will provide for matters related to the extended team.

c. As set out in P.18/2024, that guidance will state that the extended team meetings will be chaired by the relevant assessing doctor (e.g. the Coordinating Doctor, if convened during the first assessment, or the Independent Assessment Doctor if convened during the independent assessment). The chair will determine the composition of the extended team and frequency of meetings, dependent on the specific circumstances of the individual requesting assisted dying. Details of the meetings will be included in the individual's assisted dying record [see paragraph 260b].

d. In addition to discussion of the individual's eligibility for assisted dying, the extended team meetings may also be used to consider additional support the individual may require, either in relation to their assisted dying request (e.g. access to counselling services or mental health practitioners) or where the person is likely to be assessed as ineligible for an assisted death and may require signposting to other services for support.

Involvement in planning & provision of assisted death

31. **Administering Practitioner** – the doctor or registered nurse who: supports the individual to develop their assisted dying care plan; supports the individual to either self-administer the approved drugs or who will administer the approved drugs to the individual; who stays with the individual during their death.

The Coordinating Doctor may also act as the Administering Practitioner (if the individual agrees to this) but the Independent Assessment Doctor may not act as the Administering Practitioner to help preserve the independent nature of the Independent Assessment Doctor's role.

32. **Pharmacy Professional** – the pharmacist or pharmacy technician who will prepare and dispense the approved drugs. To help ensure a clear chain of control over the approved drugs, the draft law provides that the Pharmacy Professional must work for hospital pharmacy. The approved drugs cannot be prepared or dispensed from any other pharmacy.

33. **Survey - health and care professionals' participation in assisted dying survey**

P.18/2024 sets out that, post consideration of P.18/2024 by the Assembly, a survey of local health and care professionals would be undertaken to better understand if they may be willing to participate in the Assisted Dying Service.

That survey, which was undertaken in early 2025, indicates that a number of Jersey-based professionals are willing to participate in assisted dying.

This included:

- 19 doctors indicated they would be prepared to act as an assessing doctor
- 51 professionals (doctors and nurses) indicated they would be prepared to act as an Administering Practitioner
- 92 professionals (nurse, social workers, allied health professionals) indicated they would be prepared to be part of an extended team
- 22 professionals indicated they would be prepared to act as Pharmacy Professional.

See Appendix 2 for more information.

Assisted dying eligibility criteria

34. In accordance with P.18/2024, Article 2 of the draft law provides that an individual may be eligible for assisted dying if they meet the following criteria:
    a. health criteria
    b. capacity criterion
    c. decision criteria
    d. age criterion
    e. residency criterion

35. The health criteria are that the individual:

    a. has a physical condition that is expected to cause their death within 6 months (or 12 months if the condition is neurodegenerative) i.e., it is a terminal illness; and

    b. believes they cannot bear the suffering the condition causes them or is expected to cause them before their death, OR if treatment could extend their life, or make their suffering more bearable, they believe that they could not bear the suffering that the treatment would cause them

36. The draft law provides that the assessing doctor must be satisfied that the individual believes they cannot bear the suffering they are experiencing, or are expected to suffer, but it is for the individual, not the doctor, to determine their own suffering (see Article 25, paragraphs 163-166 for more detail).

37. The capacity criterion is that, when the individual is assessed, they have capacity to decide to end their life by assisted dying. Article 26 sets out the matters that the assessing doctor (or Administering Practitioner at step 6 or 7) must consider in order to be satisfied the individual has capacity. This includes a specific assisted dying capacity test (see paragraphs 167 - 170 for more detail).

38. The decision criteria are that, when the individual is assessed, their request for assisted dying is:
    a. voluntary
    b. clearly expressed
    c. settled (having been maintained consistently since their first request for assisted dying), and
    d. informed.

39. With regard to the voluntary nature of the individual's decision, Article 65 - which sets out matters related to mandatory training for assisted dying practitioners - stipulates that the training must include matters related to domestic abuse and whether someone has been coerced or pressured to do something, including coercive control and financial abuse. This is in line with proposals in the UK Bill (see Appendix 4).

40. In determining whether the individual's decision is informed, Article 28 and 29 (and Schedule 1) set out the general and specific information that the assessing doctors must provide to the individual (See paragraphs 175 - 177).

41. The age criterion is that an individual must be 18 years or older when they make their first request for assisted dying.

42. The residency criterion is that the individual must be ordinarily resident in Jersey for 12 months immediately prior to making their first request for assisted dying and continue to be resident throughout the assisted dying process. Residency is assessed throughout the assisted dying process to ensure adherence to the principle that only people resident in Jersey are eligible for an assisted death in Jersey and to safeguard against any potential cross- jurisdictional risks, for example:

    a. a health care professional being involved in the assisted dying process for an individual who is resident in another jurisdiction in which assisted dying is not lawful
    b. the individual seeking an assisted death in Jersey whilst resident, even on a short-term basis, in a jurisdiction in which assisted dying is not lawful.

Appendix 3 - case studies

Appendix 3 includes 12 studies that illustrate how the assisted dying eligibility criteria (described in Section 2 above) and the assisted dying process (described in Section 3 below) will work for different individuals depending on their personal circumstances.

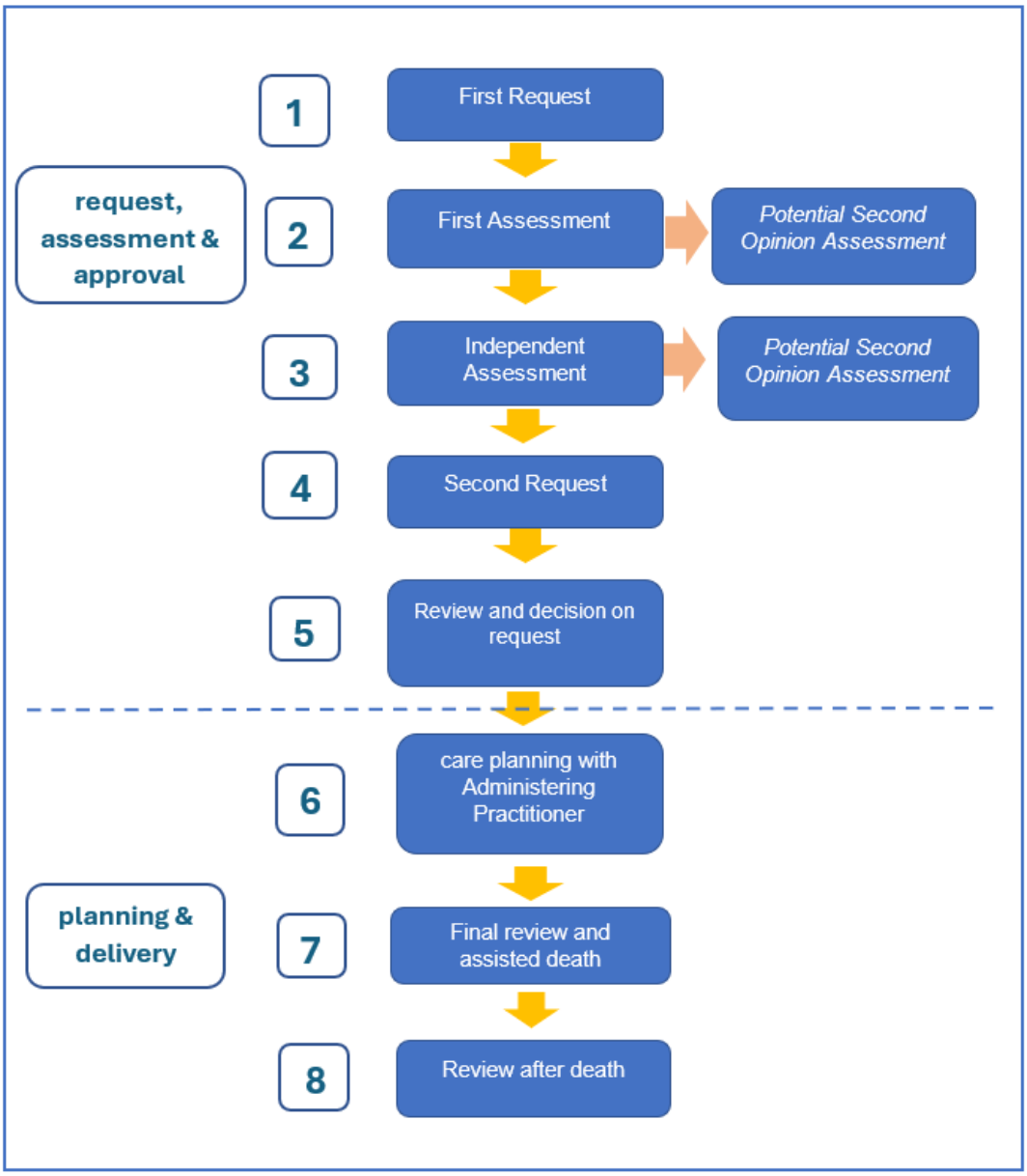
Appendix 3 includes case studies focused on individual requesting an assisted death, and health and care professionals involved the assisted dying process or caring for individuals involved in the process.

Section 3: Part 2 of draft Law - Assisted dying process and related matters

43. Part 2 of the draft law:
    - sets out matters relating to steps 1 to 8 of the assisted dying process; from first request to review after death
    - provides additional detail about the assessment, approval, and provision of assisted dying

Assisted Dying Process (Steps 1 to 8)

44. The draft law sets out the steps for the assisted dying process in accordance with P.18/2024:



Step1: First request for assisted dying (Article 3)

45. As set out in P.18/2024 the first request starts the formal assisted dying process – it signifies a shift from informal consideration of assisted dying to formal intent to initiate an assisted dying process. Prior to making a first request the individual may, over a period time, have had several discussions with the Care Navigator about assisted dying process which may have included being referred by the Care Navigator to other relevant support services.

46. The draft law provides that an individual may be referred into the Assisted Dying Service by another healthcare professional or may self-refer. Self-referral allows people direct access to the service where, for example, their GP, chooses not to refer them on the grounds that they object to assisted dying.

47. An individual must meet face-to-face with a Coordinating Doctor to make their first request. This will be captured on a first request form. As set out in P.18/2024, during that meeting the Coordinating Doctor will talk to them about assisted dying, and the assisted dying process.

48. The draft law provides that, at this first step in the process, the Coordinating Doctor must explain to the individual that they can choose whether to permit the Assisted Dying Service to share information about the individual with others (for example, with other health care professionals, friends or family members) and, whilst the individual may choose not to permit information sharing, this may impact on the assessing doctors' or Administering Practitioner's ability to determine if the individual meets the eligibility criteria.

49. The Coordinating Doctor must also determine matters related to age and residency at Step 1. In doing so they may seek relevant opinions of others (see Article 31 and paragraphs 180 - 188).

50. If the individual makes their first request (and both they and the Coordinating Doctor sign a form confirming the individual has made a first request), and the Coordinating Doctor is satisfied the individual meets the age and residency criteria, the individual may then request to proceed to the next step (step 2). As per paragraph 128, they may request to proceed to the next step at the same time as making a first request or a later date – this is because they are in control of the speed of the process.

51. The draft law provides that the Coordinating Doctor cannot accept the request to proceed to step 2, unless they reasonably believe that the request is voluntary and clearly expressed (see Article 17 and paragraph 130). At step 2 matters related to the other criteria are assessed and determined.

52. If the Coordinating Doctor is not satisfied the individual meets the age and residency requirements, or that their request is voluntary and clearly expressed, they must tell the individual and explain the reasons for their refusal. The assisted dying process then stops unless overridden by an appeal (see Article 42 and paragraphs 232 - 243).

53. In accordance with P.18/2024, the draft law permits an individual to make a new first request if an earlier assisted dying process ended, but it also provides that the Coordinating Doctor can refuse to start the process again if:

    a. the Coordinating Doctor believes the new process would end for the same reason as the previous process, or
    b. the individual withdrew from the first process before the process completed but the Coordinating Doctor reasonably believes that, in any event, the first process would have ended for another reason (e.g. they would have been found to be ineligible).

54. The above provisions allow for individuals whose circumstances change (i.e., their life expectancy was previously more than 6 months but is now six months or less) whilst

avoiding necessary distress to individuals who make repeated requests but are clearly not eligible for assisted dying under the law – including those who withdraw from previous processes.

Step 2: First assessment (Article 4)

55. If the individual completes step 1, including requesting to proceed to the next step, the Coordinating Doctor will undertake a first assessment. Depending on the circumstances of the individual, the assessment may be completed during one meeting or may require multiple meetings. Article 18 sets matters related to the location of meetings, for example Jersey and UK, and the format of meeting, for example, in-person or electronic (see paragraphs 138 - 146).

56. During the first assessment the Coordinating Doctor:
    a. must decide whether they are satisfied that the individual meets all the criteria (Articles 25 to 30 provides for how the Coordinating Doctor determines the criteria - see paragraphs 161 -179)
    b. may decide the individual has a life expectancy of 14 days or less, in which case they may override the 14-day minimum timeframe. See note on minimum timeframes, paragraph 64.

57. In making those determinations the Coordinating Doctor may or must seek relevant opinions of other professionals or connected persons. A connected person is someone who has a personal relationship with the individual (e.g.: a family member, friend, neighbour, or colleague).

58. The Coordinating Doctor – and all other assessing doctors- may seek a relevant opinion when it will be helpful to them to understanding a matter (for example, they may speak to family members to better understand why the individual is refusing treatment). They must seek a relevant opinion when the opinion is necessary to help them decide a matter (for example, they must get an expert in capacity to undertake an assessment if they are unable to determine whether the individual has capacity). Article 31 provides information on relevant opinions - see paragraphs 180 - 188.

59. If the Coordinating Doctor determines that the individual does not meet one of the criteria, they are not required to assess all the criteria. For example, if they are not satisfied that the individual's condition is terminal - and hence the individual could not be found to meet all the eligibility criteria - the Coordinating Doctor is not required to assess the whether the individual meets the capacity or decision criteria. Criteria that have not been assessed in these circumstances are referred to as unassessed criteria (See Article 24). Unassessed criteria can be considered as part of a second opinion assessment if a second opinion assessment is undertaken (See paragraph 200)

60. If the Coordinating Doctor is not satisfied that the individual meets the criteria, they must tell the individual and provide written confirmation that they do not meet the criteria, which

criteria they do not meet and why, and which, if any, are criteria are unassessed. The process then stops unless overridden by a second opinion assessment (see Articles 32/33 and paragraphs 189 - 201) or an appeal (see Article 42 and paragraphs 232 - 243).

61. If the Coordinating Doctor is satisfied that the individual meets the criteria they must, when meeting with the individual, sign a form stating this.

62. If the individual then wishes to request to proceed to the next step of the process they may do so, but the Coordinating Doctor may only accept this request if they reasonably believe the individual's request is voluntary and clearly expressed (see Article 17).

63. Note: If the Coordinating Doctor did not decide to override the 14-day minimum timeframe during the first assessment (because at the time of the first assessment the individual's life expectancy was more than 14 days) the Coordinating Doctor – or another doctor if permitted by the draft law – may make this decision at any time after the first assessment if the individual's health has deteriorated.

64. **Note: Minimum timeframes**

a. In accordance with P.18/2024, Article 9 of draft law provides that an individual's assisted death must be at least 14 days after the day on which the individual has made their first request and completed Step 1.

b. 14 days is considered sufficient time for assisted dying process to be completed, and for the assessing doctors to be confident that an individual's request for an assisted death is settled (in accordance with the eligibility criteria), whilst not unduly extending any suffering and uncertainty. This is in line with some other jurisdictions that permit assisted dying.

c. The draft law also provides that the minimum timeframe may be overridden if, in the opinion of the Coordinating Doctor and the Independent Assessment Doctor, the individual is likely to die in less than 14 days from the date on which they made their first request. In the cases there will be no minimum timeframe.

d. Overriding the 14 days minimum timeframe automatically includes removal of requirement for at least 2 working days period between approval of an assisted death (at Step 5) and the administration of the approved drugs (at Step 7). The 2 working days period is to allow for appeals from a person with a special interest in the care and treatment of the individual. The minimum timeframe is provided for in Article 9. Appeals are provided for in Article 42.

e. There is no maximum timeframe for an assisted death (i.e., the draft law does not stipulate that the process must take no more than a given number of months). This is because an individual must be able to dictate the pace at which they move through the process – except for where the minimum timeframes apply.

Step 3: Independent assessment (Article 5)

65. If the individual completes step 2, including making a request to proceed to step 3, then the Independent Assessment Doctor will undertake a second assessment to decide whether the individual meets the health criteria, the capacity criteria, the decision criteria and the residency criteria. They do not need to determine the age criteria as the fact that the individual is aged 18 or over has already been determined at step 1.

66. The independent assessment process mirrors the first assessment process – as described in paragraphs 55 -63 above - except that the draft law provides that Independent Assessment Doctor may review the Coordinating Doctor's first assessment form and any relevant opinions that have already been sought.

67. This provision differs from P.18/2024, which set out that the Independent Assessment Doctor may consult the Coordinating Doctor and review relevant opinions but may not review the Coordinating Doctor's first assessment form. The restriction has been removed in response to stakeholder feedback (including from the health and care professionals working group) on the basis that permitting the Independent Assessment Doctor to consult the Coordinating Doctor (as agreed in P.18/2024) but then restricting access to the first assessment form is perverse, on the basis that the Coordinating Doctor can just tell the Independent Assessment Doctor the information captured on the first assessment form.

68. The draft law does, however, introduce new provisions that work to ensure the independence of the Independent Assessment Doctor by requiring the Independent Assessment Doctor to disclose any interests vis-à-vis their relationship to the Coordinating Doctor (see Articles 20 & 22 and paragraphs 152 - 155). These disclosure provisions are over and above the safeguards provided for in P.18/2024.

Step 4: Second request (Article 6)

69. If the individual completes step 3, including making a request to proceed to step 4, they may then make their second assisted dying request.

70. The second request process broadly mirrors the first request process except that the draft law provides that the signing of the second request form must be witnessed by a person aged 18 or over who knows the individual well enough to be able form a belief as to whether the individual's request for an assisted death is voluntary; clearly expressed; settled and informed but who:
    a. is not a close relative of the individual
    b. is not an assisted dying practitioner involved in their assisted dying process
    c. does not benefit or believe they may benefit, financially or in any significant way, from the individual's death

71. The requirements for the witness, which are set out in Article 17 of the draft law, accord with P.18/2024. A witness is not required at step 1 as the primary purpose of the first request is to start the formal assessment process, whereas the second request has more significant implications as it signifies continued intent to have an assisted death.

72. As set out P.18/2024, it is envisaged that second request form, to be prescribed by Order, will include a form of declaration, for example: *I declare that I am making a second request for an assisted death. I make this request voluntarily and without coercion. My decision to have an assisted death is clear, settled and informed. My wish is made in full knowledge of alternative options for my ongoing care and treatment. I fully understand the nature and effect of this decision.*

73. Having made their second request, the individual can then request to proceed to the next step (step 5) when they are ready to so do. As set out in Article 17 (paragraphs 127 - 138) the Coordinating Doctor may only accept the individual's request to proceed to Step 5 if they reasonably believe that:
    a. the individual has capacity to request to end their life by assisted dying and
    b. their request is voluntary, clearly expressed, settled and informed.

74. If the Coordinating Doctor cannot accept the second request or the request to proceed to the next step, they must inform the individual in-person and in writing, stating the reasons for this decision. The process the stops unless overridden by an appeal (see Article 42 and paragraphs 232 - 243).

Step 5: review and decision on request for assisted dying (Article 7)

75. At Step 5 the Coordinating Doctor must decide whether to approve an individual's request for assisted dying. They must approve the request if they are satisfied that the individual has completed steps 1 to 4 in accordance with the law or, if not satisfied they must refuse the request.

76. In accordance with P.18/2024, the Coordinating Doctor must review the individual's records and ensure all steps have been completed before they make their decision. If any steps have not been completed, they must try to ensure they are completed, for example by requiring the step to be completed.

77. The Coordinator Doctor may, at this stage, also decide to override the minimum 14-day time frame if they and the Independent Assessment Doctor (or another doctor registered with the Assisted Dying Service) are satisfied, or have previously determined they are satisfied, that the individual's condition is likely to cause their death in 14 days or less (see paragraph 64).

78. The individual's request for an assisted death may be approved if the Coordinating Doctor is satisfied the assessment process accords with the law.

79. As set out in P.18/2024, the draft law provides there will be no expiry date on an assisted dying request approval. The decision not to include an expiry date is a safeguard, so that pressure is not placed on the individual to end their life through an assisted death when they are not yet ready to do so, simply because their approval is close to expiry.

80. It is known that an approval for an assisted death can have a palliative effect, providing the individual with a sense of control over the end of their life. Evidence from other jurisdictions suggests that, in some cases, the knowledge that a person has the option to end their suffering brings such comfort that they choose not to proceed to an assisted death. For example, 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.

81. The individual may, at a time of their choosing, request to proceed to the next step (Step 6). The Coordinating Doctor must accept the request to proceed, if the Coordinating Doctor reasonably believes the request is voluntary and clearly expressed (as per Article 17).

82. If the Coordinating Doctor decides to refuse the request, they must meet with the individual and tell them in person and in writing the reasons why the request is not approved. The process then stops unless overridden by an appeal (see Article 42 and paragraphs 232 - 243).

Step 6: Care planning (Article 8)

83. If an individual is approved for an assisted death they may proceed to the care planning phase (Step 6), At this step, the Administering Practitioner takes on coordination of the process. As set out above, the Coordinating Doctor may also act as the Administering Practitioner (see paragraph 31).

84. During the care planning stage, the draft law requires the Administering Practitioner to inform the individual:
    a. that they may withdraw their request for assisted dying at any time before the drugs are administered
    b. that they are expected to die if the drugs are administered
    c. about the approved drugs
    d. about options for administration of the approved drugs (such as swallowing or intravenous injection) and options for who administers the drugs (the individual may wish to self-administer or wish the Administering Practitioner to administer the drugs) and any risks associated with the options
    e. about options for family and friends to be present or involved in the assisted death, and any associated risks
    f. about options for where the assisted death may take place (see paragraph 93 below)

85. The Administering Practitioner must also provide information about the implications of the following choices which the individual may decide to make at Step 6. These include the choice to:

a. provide consent to the continued carrying out of an assisted death at Step 7 (see paragraph 94)
b. waive the requirement for future capacity at Step 6. If the individual does waive the requirement for future capacity, they must also make their final request to end their life at Step 6 as opposed to at Step 7 (see paragraph 95)
c. make an advanced decision to refuse treatment (see paragraph 96) if an advance decision is not already in place.

86. The information set out above will have been previously discussed with the individual as part of Steps 1 to 4 - in accordance with the assessment process operational guidance (as required under Article 62) - but at step 6 there is an explicit legal requirement to ensure all the information is reiterated.

87. During step 6, the Administering Practitioner and individual must agree on a care plan which must record the individual's preference for their assisted death, including:
a. time and place of their assisted death
b. who will administer the drugs (self-administration or practitioner administered) and how they will be administered (for example, orally or by IV)
c. their choices with regard to providing consent to the continued carrying out of an assisted death and / or waiving the requirement for future capacity and / or advance decisions to refuse treatment.

88. Where the individual wishes the Administering Practitioner to administer the approved drugs, the care plan must set out the Administering Practitioner's agreement to do so. As set out in Article 36, an Administering Practitioner has the right to refuse to administer the approved drugs to an individual and may opt to only support self-administration (unless medical complications arise after the individual has self-administered the approved drugs and the Administering Practitioner needs to intervene).

89. **Self-administration / practitioner administration**

a. This draft law permits an Administering Practitioner to opt-out of administering the approved drugs to the individual, as opposed to supporting the individual to self-administer the approved drugs because it is recognised that some health care professionals only support assisted dying when the individual brings about their own death through self-administration of the approved drugs. (The rationale being that, if assisted dying is about personal choice and autonomy, the person must take the final step to end their life by self-administering the assisted dying substance)

b. In accordance with P.18/2024, the draft law provides for both self-administration and practitioner administration on the basis that restricting assisted dying to self-administration can significantly limit options for some individuals. This dual provision differentiates the draft law from the UK Bill which only permits self-administration (see Appendix 4) but accords with the Ethical Review Panel who note that there are

reasonable arguments in favour of, and against, both self-administration and practitioner-administration.

c. In providing for both modes of administration, the draft law nevertheless provides that Administrating Practitioners can decide if they opt out of practitioner administration (as can the administration witness – see paragraphs 99 - 103)

90. The draft law provides that the care plan agreed at step 6 may be amended, prior to the assisted death taking place, but any amendments must be signed by both the individual and the Administering Practitioner.

91. In addition to agreeing the care plan, the Administering Practitioner must confirm that arrangements have be made for a Certifying Doctor to attend the individual within 14 days prior to their death (if they have not already done so). This is because, under the Marriage and Civil Status Law, a Certifying Doctor is only qualified to complete a Medical Certificate of Fact and Cause of Death if they attended the person within 14 days prior to their death. (See paragraphs 115 - 116).

92. Note: whilst the Administering Practitioner must confirm the arrangement relating the Certifying Doctor at step 6, in some instances the Certifying Doctor may have already attended the individual, particularly if they have a life expectancy of 14 days or less.

93. *Place of assisted death*

a. The draft law does not restrict the places where an assisted death may be carried out (for example, it could be a private home; care and nursing facilities owned by GoJ or managed by GoJ; care and nursing facilities not owned by GoJ; hospital facilities) but Article 9 of the draft law provides that:
- the place must be approved by the Administering Practitioner, and
- the Administering Practitioner must be satisfied that an assisted death can be safely carried out in that place, having considered any risks that may make it unsuitable, and the views of others who live there.

b. The draft law also provides that:
- where the place is a care home that is not provided by Health and Care Jersey, the provider or manager must have agreed that the assisted death may be carried out there
- operational guidance on matters related to approved places must be developed.

c. As set out in P.18/2024, the operational guidance will set out factors that must be considered in approving a place. For example:
- if the assisted death is to take place in a care facility, there will need to be consideration of other individuals that may be present or close by during the

assisted death (for example, persons and staff in the same hospital ward, even if the assisted death takes place in a private room)

- if the person wishes to die at home but lives in shared accommodation the Administering Practitioner will need to consider whether this may result in disruption and / or distress and / or potential harm.

Note: The Minister, in response[12] to Scrutiny's review[13] of P.18/2024 proposals has committed to provide details of to timeline and stakeholders to be involved in discussions on matters related to the use of Jersey General Hospital as a place of last resort for assisted deaths. This information will be provided in an addendum to be this report to be lodged before debate (See paragraph 10).

94. *Consent to continued carrying out of an assisted death*

a. *Consent to continued carrying out of an assisted death* was referred to as *Consent to proceed* in P.18/2024. Where the individual provides consent, the Administering Practitioner may take appropriate action at Step 7 to bring about the individual's death if compliance with the care plan does not result in their death and the individual has lost the capacity to consent to that action (for example, they are unconscious). Appropriate actions may be required if, for example, the time to death is protracted post-administration of the approved drugs in which case the Administering Practitioner may:

- administer different approved drugs or more approved drugs
- administer approved drugs themselves, as opposed to the individual self-administering the drugs
- administer the approved drugs in a different way (for example, by injection rather than swallowing).

b. Examples of the medical complications that may require non-compliance with the care plan include regurgitation and vomiting, or seizure; delayed effectiveness of oral medication (for example, where the person has not died within 60 minutes of taking the substance orally); loss of consciousness before all the oral medication has been taken.

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),

[12] S-R-3-2024-Res_1.pdf
[13] Report-Review-of-Assisted-Dying-14-May-2024_1.pdf

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.

c. Provisions relating to the waiver of requirement for future capacity accord with those set out in P.18/2024 except that P.18/2024 referred to a *waiver of final confirmation of consent.* The draft law also clarifies how the waiver will operate in practice. These clarifications include:

- if the individual chooses to waive the requirement for future capacity at Step 6, they must also make their final request to end their life at Step 6, as opposed to at Step 7. The effect being that, at Step 6 the individual is saying "I want an assisted death, and I consent to the administration of the approved drugs on the date set out in my care plan even if, on that date, I no longer have capacity"

- the Administering Practitioner can only confirm the request to waive requirement for future capacity if, at Step 6, they are satisfied that the individual has the capacity to make their final request for an assisted death and they reasonably believe the final request is voluntary

d. The waiver of requirement for future capacity relates to both the requirement for capacity at step 7 (as per P.18/2024) and the requirement for capacity to request to proceed from Step 6 to Step 7. The proposals presented in P.18/2024 did not include matters related to the request to proceed from Step 6 to Step 7, which could have unintended consequences for an individual who waived the capacity requirement at Step 7 but who had lost capacity *before* requesting to proceed to Step 7.

e. As set out in P.18/2024, 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 resistance to the administration by words, sounds or gestures (for clarity, reflexes and other types of involuntary movements, such as response to touch or the insertion of a needle, would not constitute refusal).

f. As set out in paragraph 10, the addendum to be published by Minister for Health and Social Services will include details and processes for establishing refusal or resistance to an assisted death by a person who has lost decision-making capacity.

96. *Advanced decision to refuse treatment*

a. Advance Decisions to Refuse Treatment (ADRT) are permitted under the draft law as in any other end of life circumstances in Jersey[14]. ADRTs – which can include a *do not attempt cardiopulmonary resuscitation* - provide clear instruction to health care

[14] ID Making an Advance Decision to Refuse Treatment (ADRT) -Guidance Notes.pdf

providers about when a patient does not want to be provided life sustaining measures in the event of a medical emergency.

b. Many individuals requesting an assisted death will already have ADRT's in place. However, in the highly unlikely event that an ADRT is not in place, and the individual declines to make an ADRT, this may have implications in the period AFTER the assisted death being approved but BEFORE the approved drugs are administered.

c. For example, if the individual were to have to have a medical emergency health care professionals would need to consider whether to attempt life sustaining measures because there is no ADRT to instruct them not to.

d. In practice, if they knew about the assisted dying request, it is unlikely that they would proceed to resuscitation as this would seemingly contradict the assisted dying request (and therefore not be considered in the person's best interests) but the lack of the ADRT creates a degree of uncertainty for health professionals. Furthermore, if the health care professional does not know about the assisted dying request, this could result in resuscitation of an individual who wants an assisted death.

e. Article 10 of the draft law provides that AFTER the approved drugs have been administered, a person need not act to preserve the individual's life if the individual has not requested that.

Step 7: Final review and carrying out of assisted death (Articles 9 - 12)

97. The draft law provides that, on the agreed day of the assisted death, the Administering Practitioner must undertake a final review to determine that the individual still has capacity to proceed (unless the individual waived the requirement for future capacity at step 6) and their wish to proceed is still voluntary.

98. The Administering Practitioner must also be satisfied that: any appeals have been determined or withdrawn; that the Certifying Doctor has attended the individual within the last 14 days; and that the assisted death will accord with the minimum timeframes set out in the draft law.

Administration witness (Article 9)

99. In accordance with P.18/2024, a witness must be present at the carrying out of the assisted death to watch preparation for, and the administration of, the approved drugs.

100. The witness must be a nurse, a doctor or another assisted dying practitioner. P.18/2024 had proposed that the witness could only be another assisted dying practitioner (if the assisted death is to take place in a private residence) or another doctor or nurse if the assisted death is to take place in Jersey General Hospital. However, following feedback from stakeholders, the draft law also permits doctors and nurses working in other locations to act

as witnesses (for example a nurse working for a home care provider) – although in practice it is anticipated that witness will most usually be another assisted dying practitioner.

101. Any professional can refuse to act as a witness for an assisted death or refuse to act as witness if the Administering Practitioner is administering the approved drugs, as distinct from the individual self-administering the drugs (see Article 36 and paragraph 211).

102. As noted in P.18/2024, the administration witness may also undertake additional tasks such as providing practical and emotional support to the individual or any family who are present, or providing clinical support under the direction of the Administering Practitioner (for example, setting up IV tubes and preparing the substance if they are a registered nurse or a doctor) but there is no statutory requirement to undertake these additional tasks because placing any additional statutory requirement on them may distract from their core duty to witness the preparation and administration of the approved drugs.

103. The requirement for a witness provides an important safeguard as it ensures that there is no lone practitioner.

Carrying out the assisted death (Article 10)

104. The assisted death must, as far as is practicable, accord with the care plan agreed at step 6

105. If the individual has chosen for the Administering Practitioner to administer the drugs, the Administering Practitioner must administer the drug and remain nearby until the individual dies.

106. If the individual has chosen to self-administer the drugs, the Administering Practitioner must give them the drugs, tell them and their helper (if they have a helper) how to take the drugs, watch whilst this happens, and then remain nearby until the individual dies.

107. In accordance with P.18/2024, the draft law provides that where the individual has chosen to self-administer the approved drugs, they may be helped by a family member or friend (for example supporting the person to bring the cup to their lips). This would likely be an extension of the care and support that loved ones have been providing over the previous days and weeks. Matters relating the involvement of a helper will be discussed and agreed as part of the care plan (Step 6).

108. In the event that compliance with the care plan does not result in the individual's death, the administration practitioner may take a number of actions - including administering more approved drugs or different approved drugs, or administering the drugs in a different way. This includes where the individual still has capacity to consent, where the individual provided *consent to the continued carrying out of an assisted death* and where the individual does not have capacity, but they *waived the requirement for future capacity*.

109. The draft law provides that a person need not act to preserve the individual's life once the approved drugs have been administered, if the individual has not requested this (see paragraph 96).

Delaying or stopping assisted death (Article 11)

110. The draft law provides that the Administering Practitioner:

a. may delay an assisted death if the individual does not have capacity to give final consent at that point in time (and there is no wavier for future capacity in place) but Administering Practitioner believes this may be due to waiving capacity as a result of their conditions or their medications – for example, on a different day, the individual may be in less pain and less heavily medicated and able to give final consent. If Administering Practitioner does delay, they must decide a new date (in consultation with the individual, if possible) on which to reassess the individual and determine their capacity

b. may stop an assisted death if they decide the individual does not have capacity (and there is no wavier for future capacity in place), or their request is not voluntary. The decision to stop may be overturned by appeal.

Disposal of approved drugs (Article 12)

111. The Administering Practitioner must dispose of any remaining approved drugs as soon as possible after the assisted death has been carried out (or after the decision to delay or not carry out the assisted death). Disposal must be accordance with relevant legislation that governs the control of drugs.

Step 8: Review after death (Article 13)

112. In accordance with P.18/2024, the draft law provides that as soon as reasonably practicable after the assisted death:

a. the Administering Practitioner must complete and sign a form specifying details of the assisted death (for example, the time of the administration of the drugs; the time of death; dosage and drugs used; details of the administration process; details of any complications that may have arisen relating to the administration of the drugs), and

b. the step 7 witness must also sign that form confirming it has been accurately completed.

113. In this context, *as soon as reasonably practical* means where at all possible, this takes place within the hour or so immediately following the death.

114. Within 2 working days of the assisted death, the Administering Practitioner must:
a. provide a copy of the signed form specifying the details of the assisted death to the Review Panel (see Article 94 and paragraphs 296 - 303), and
b. provide a copy of both the form specify the details for assisted death (as signed as Step 8 and the form completed after the Administering Practitioner's review (as signed at step 7) to the certifying doctor.

115. The Certifying Doctor must then view the individual's body and complete the Medical Certificate of Fact and Cause of Death ("MCFCD") in accordance with the requirements

of the Marriage and Civil Status (Jersey) Law 2001. The MCFCD must be provided to the relevant registrar within the period of 5 days following the death. A relevant registrar can be either a Parish Registrar or the Superintendent Registrar, dependent upon if the parish has a registrar in post at the time of the assisted death.

116. As set out in above, in order to be qualified to complete the MCFCD the Certifying Doctor must have attended the individual within the 14 days prior to their death. The draft law requires the Administering Practitioner to arrange for this to happen at Step 6 if it has not already happened.

117. As set out in P.18/2024, an assisted death will be recorded in the same way as all other deaths in Jersey. This means that the MCFCD will record the disease or condition leading to the death and any antecedent causes (amongst other matters). In the case of an assisted death this would mean that MCFCD would state, for example, that the condition leading to the death was cardiorespiratory arrest which was caused by administration of approved drugs. As each entry into the register of death is publicly available an individual's assisted death would be a matter of public record.

118. As noted in Assisted Dying Phase 2 public consultation[15] in some jurisdictions (for example Western Australia) the death certification process does not record the death as an assisted death; the cause of death is instead recorded as the underlying illness which the person had which made them eligible for an assisted death. This is intended to protect the privacy of the person. However, in other jurisdictions the law and associated guidance strives for transparency and acceptance around the assisted dying process (for example, in New Zealand) where the death is recorded as an assisted death. In Jersey the proposed approached, as provided for in the draft law, it to promote transparency and, by so doing to help remove stigma associated with end-of-life choices.

119. For the purposes of clarity, assisted deaths will not be recorded as suicide because they are not suicide (as provided for in Article 43 of the draft law). This is the case in all other jurisdictions where assisted dying is legal.

Matters relating to the Assisted Dying Process

120. Part 2 of the draft law also sets out additional matters related to the assessment, approval and provision of an assisted death.

Consent to sharing the individual's information (Article 14)

121. In accordance with P.18/2024, the draft law provides that the individual must give consent for an assisted dying practitioner to share information about that individual with another person, for example a family member or health and care professional. Consent, and any changes to the consent must be recorded in the individual's records.

[15] Assisted Dying Consultation Report.pdf

122. Disclosing information without consent may be an offence under the law. See Article 41 (paragraph 225 - 231) and Article 52 (paragraphs 247 - 251).

Withdrawing request or pausing the process (Article 15)

123. The draft law provides that the individual may withdraw their request for an assisted death at any point in the process by telling any assisted dying practitioner involved in their assisted dying process that they are withdrawing. The practitioner must tell the Coordinating Doctor (if the individual did not tell the Coordinating Doctor in the first instance). The Coordinating Doctor will confirm with the individual that they wish to withdraw and record the withdrawal on a written notice.

124. As set out in paragraph 53, the draft law permits an individual to make a new first request having previously withdrawn a request, but the Coordinating Doctor can refuse to start the process again if the conditions set out in Article 1 are met. As set out in P.18/2024, where an individual has withdrawn a previous request but then started the process again from the beginning, the operational guidance will provide that the assessing doctors must consider whether the previous request withdrawal indicates that their wish for an assisted death is not a settled wish.

125. The individual may pause the process at any point by choosing not to request to proceed to the next step.

Another person may sign forms (Article 16)

126. Where the individual is physically unable to sign any assisted dying form, another person may sign it on their behalf. That person must be aged 18 or over, must be together with the individual when the form is signed, and cannot be:
    a. an assisted dying practitioner or involved in the individual's assisted dying process
    b. the witness to the individual's second request (Step 4).

Request to proceed to next step (Article 17)

127. The requirement to request to proceed to the next step is detailed in the assisted dying process described above in paragraphs 35 to 68. The request to proceed provisions accord with P.18/2024 except P.18/2024 referred to a *step transition process*. *Step transition* is renamed *request to proceed* to more accurately the intent and outcome of these provisions.

128. It is anticipated that the individual will, in many cases, request to proceed to next step during the same meeting at which they are told the outcome of the previous step (for example, at during the same meeting at which they are told the outcome of their first assessment, they will request to proceed to their second assessment) however it is imperative that the individual must be in control of the assisted dying process and must be able to choose whether to proceed to the next step, and be able to do so at their own pace. The request to proceed process provides for this. It is an essential safeguard that allows for:

    a. an individual to pause the process between steps for as long as they wish
    b. an individual to 'restart' the process when / if they are ready to do so by requesting to proceed

c. the Coordinating Doctor (or the Administering Practitioner at Step 6) to decide key matters related to nature of the individual's request to proceed to the next step – particularly if there has been a protracted period of between the different steps.

129. A request to proceed to the next step must be made at the end of previous step if the individual is to complete the previous step (for example, the individual only completes Step 2 if they have also requested to proceed to Step 3). The exception being at the end of Step 7 as the individual will be deceased.

130. At the end of Steps 1 to 6 the Coordinating Doctor (or the Administering Practitioner at Step 6) must reasonably believe the individual's request to proceed is voluntary and clearly expressed (i.e., the individual is not being coerced or pressured by a third party to proceed to the next step).

131. At the end of step 4 (Second request for assisted dying), the Coordinating Doctor must also reasonably believe that the individual's request to proceed is:
   a. settled – because they have maintained this wish since making their first request for an assisted death at step 1
   b. informed – because the assessing doctors have informed them of the general and specific information about assisted dying (as set out at Article 28 and 29) and the assessing doctors are satisfied that the individual understood the information (see paragraphs 175 - 177).

132. Furthermore, at the end of step 4 (Second request), in order to accept an individual's request to proceed to step 5, the Coordinating Doctor must reasonably believe that the individual has capacity to request to end their life by assisted dying. Reasonable belief of capacity is not required at:
   a. at the end Step 1 (First Request) to proceed to Step 2 (first assessment) as no assessment of capacity is undertaken until Step 2
   b. at the end of Step 2 (First assessment) to proceed to Step 3 (independent assessment) because during both those steps the assessing doctor must assess the individual's capacity
   c. at the end Step 3 (independent assessment) to proceed to Step 4 (second request) because capacity has been determined during Step 3
   d. at the end of Step 5 (review and decision on request) to proceed to Step 6 (care planning) as Step 5 is a wholly administrative process

133. At the end of Step 6 (care planning) to proceed to Step 7 (final review and carrying out of an assisted death), the Administering Practitioner must also reasonably believe that the individual has capacity to request to end their life by assisted dying unless, at Step 6, the individual waived the requirement to future capacity (see paragraph 95).

134. These arrangements provide an additional series of 'anti-coercion' safeguards, requiring the assessing doctors to consider the possibility of coercion not just during step 1 to 7, but also as the individual transitions between steps. This is important because, if an individual

delays transition to the next step, there may be underlying hesitancy that needs examination.

135. The Coordinating Doctor or Administering Practitioner's reasonable belief must be based on their meetings with the individual and may also be based on the relevant opinions of others (see Article 29 and paragraphs 180 - 188).

136. If the Coordinating Doctor or Administering Practitioner do not reasonably believe any of the matters they are required to believe as part of the request to proceed process, they must tell the individual in person and in writing, and the explain the reasons for their decision.

137. The individual may ask them to reconsider their decision. The doctor or Administering Practitioner may reconsider their decision, if they think doing so might change that decision but they are not obliged to (for example, if they are of the view that individual no longer has capacity or is being subject to coercion). In reconsidering any decision made under Article 17, the doctor or Administering Practitioner may take into account any additional information provided by the individual.

138. Whilst the draft law provides for reconsideration of a reasonable belief as part of process of proceeding to the next step, this does not apply to decisions which require the assessing doctor or administrating practitioner to be satisfied of a matter (for example during the first or second assessment, where they have assessed the individual and are satisfied the individual meets the capacity criteria). Where the individual – or a person with a special interest – disputes an assessing doctor's or administrating practitioner's decision that they are satisfied of a matter, they must appeal this decision under Article 42.

Location/format of meetings (Article 18)

139. Article 18 provides that all the meetings required under the draft law must take place in Jersey (i.e., the individual and / or the assisted dying practitioners must be in Jersey) unless any person is permitted or required, by Order, to be elsewhere.

140. Article 18 then provides that the persons must meet in person, unless the meeting is an additional meeting (an additional meeting being for example, a phone call that takes place after an in-person assessment during which the assisted dying practitioner is following up on a specific matter, such as providing additional information about pain relief). However, unless provided for by Order, the meeting participants must still be in Jersey (i.e., the individual at home in Jersey on a phone call with the Coordinating Doctor who is also in Jersey). The operational guidance on assessing individuals for assisted dying will set out matters and protocols related to electronic meetings.

141. P.18/2024 had stated that UK-based professionals may provide relevant opinions whilst in the UK (for example, a London-based oncologist could provide an opinion on the individual's prognosis to an assessing doctor from their London office). However, since the P.18/2024 debate there has been further engagement with the General Medical Council (GMC), the British Medical Association (BMA) and the UK Ministry of Justice (MOJ) who have confirmed that the current legal position for health professionals practising in the UK

is unclear and that, a professional who provides a relevant opinion in relation to an individual's request for assisted dying in Jersey, may contravene Section 2 of UK Suicide Act 1961 and commit the offence of 'encouraging or assisting the suicide or attempted suicide of another individual' if they are in the UK at the time of providing that opinion.

142. Hence the BMA currently recommends that their members should not '*write medical reports specifically to facilitate assisted suicide abroad*'[16] which means that, as matters currently stand, a UK-based professional giving a relevant opinion under the Jersey Assisted Dying Law must travel to Jersey to do so. However, given the evolving position in the UK, with the Terminally Ill Adults (End of Life) Bill due to have its second reading in the House of Lords in September, this position may change in the very near future.

143. For this reason, the draft law sets out that all meetings must be held in Jersey but provides for an Order-making power so that if the UK position changes, the law can provide for meetings to be held in the UK. Note: as an additional safeguard, the draft law also places a requirement on an assessing doctor or administrating practitioner, when requesting a relevant opinion, to advise the professional providing the opinion (if they are not in Jersey) to consider their local legalisation to ensure they do not unintentionally act outside of that legislation.

144. The Order-making power also provides future flexibility should the delivery of healthcare change in the coming years and electronic meetings become more commonplace due to improved digital information sharing and assessment techniques.

145. The Order-making power does not, however, allow for meetings where a witness is required to place in an electronic format. These meeting must be in person as they provide an important safeguard.

146. Note: in the event a UK based professional travels to Jersey to undertake an assisted dying assessment or provide a relevant opinion under Jersey Law, they will not be committing an offence under UK law.

Disclosure of interests in relation to individuals (Article 19 & 21)

147. A professional involved in an individual's assisted dying request must disclose any interests they may have in relation to that individual – both at the start of their involvement or, during the process, if they become aware any emerging interests. This includes:
    a. any assisted dying practitioner involved in the process, Care Navigator or certifying doctor
    b. a professional providing a relevant opinion
    c. a person who provides communication support (unless they are family member etc) or independent advocacy.

148. If an interest is disclosed, this must be reviewed by the interests review officer to determine if it is problematic / potentially problematic for example, if the professional:

[16] bma-responding-to-patient-requests-for-assisted-dying-20250074.pdf

a. is a close relative of the individual
b. may benefit financially or in any significant way from the individual's death
c. has an interest that may be seen to conflict with the individual's assisted dying process to such an extent that the review officer is of the opinion they should not be involved (for example, the individual previously made a complaint about the professional, even if that complaint was not upheld)

149. The interests review officer is the HCJ Medical Director or someone appointed by the Medical Director as they are relevant lead professional (for example, the Chief Pharmacist may review any interests declared by a Pharmacy Professional) .

150. If the review officer decides the professional's involvement is a problem, that professional must not be involved in the process, and if they have already been involved, any step completed only because of their involvement must be repeated.

151. The provisions above are in addition to the requirement for all professionals to declare any potential interests on registration as an assisted dying practitioner (see paragraph 288).

Disclosure of interest in relation to independent assessment (Article 20 and 22)

152. The draft law provided that the Independent Assessment Doctor, in addition to disclosing their interests in relation to the individual, must disclose any interests they may have in relation to the Coordinating Doctor prior to undertaking an independent assessment.

153. If an interest is disclosed, this must be reviewed by the interests review officer to determine if it is problematic / potentially problematic for example, if the Independent Assessment Doctor:

a. is a close relative of the Coordinating Doctor
b. has a personal relationship with the Coordinating Doctor (such as a family member, friend, neighbour)
c. has a work-based or financial relationship (e.g.: are business partners) with the Coordinating Doctor which conflicts, or is seen to conflict, with the independence of their assessment (for example, they have direct or supervisory line to Coordinating Doctor.

154. If the review officer decides the Independent Assessment Doctor's relationship with the Coordinating Doctor is a problem, they must not be involved in the process, and if they have already been involved, any step completed only because of their involvement must be repeated.

155. These provisions, which were not set out in the P.18/2024 proposals, were introduced following feedback from stakeholders with a view to ensure the independence of the Independent Assessment Doctor through an examination of any 'hierarchical connection', whilst recognising the challenge establishing total independence and professional

separation in a small island jurisdiction. An additional element has been added to the draft law that did not feature in P.18/2024 proposals.

Independent advocacy and communication support during the assisted dying process (Article 23)

156. The draft law places a requirement on assisted dying practitioners to:
   a. determine whether the individual requires independent advocacy or communication support to receive, understand or convey information about their assisted dying request, and
   b. try to arrange this independent advocacy or communications support (note: the financial and resource information, as set out in paragraphs 335 & 343, includes monies associated with the provision of advocacy and communications support)

157. In deciding whether independent advocacy or communications support is required, the practitioner may seek the relevant opinions of others.

158. P.18/2024 did set out that advocacy support should be made available, but following feedback from stakeholders, the Minister has determined the Assembly should, by Regulation, make detailed provision in relation to independent advocates. It is envisaged this detailed provision will broadly mirror the provisions made in other Jersey laws, such as the Children and Young People (Jersey) Law 2022; Mental Health (Jersey) Law 2016 and Capacity and Self-Determination (Jersey) Law 2016.

159. As set out in paragraphs 309 & 313, it is intended that the Minister will bring forward the independent advocacy regulations before the assisted dying law comes fully in force.

160. Note: the ability to provide for independent advocates by Regulations mirrors the draft UK Assisted Dying Bill (see Appendix 4).

Additional requirements for assessments and determining eligibility

161. The requirements for assessing an individual's eligibility for assisted dying are set out in Articles 25 to 30 of the draft law, which also provides that the Committee must arrange for the development of operational guidance specifically focused on the assessment process (see Article 62 and paragraph 260).

Life expectancy (Article 25)

162. An assessing doctor, when predicting an individual's life expectancy (6 months, 12 months in relation to a neurodegenerative condition, or within 14 days or less if overriding the minimum timeframe), must predict the matter based on their medical knowledge and their assessment of the individual. They may also base their prediction on a relevant opinion (for example, where they have sought the opinion of a professional who has expertise in the individual's condition).

Suffering and treatment (Article 25)

163. When assessing whether an individual can bear the suffering (or anticipated suffering) caused by their condition or the treatment for the condition, the assessing doctor need only

satisfy themselves that the individual believes they cannot bear the suffering, or would not be able to bear the expected suffering - irrespective of what the assessing doctor personally believes about the suffering / expected suffering.

164. This is because, as set out on P.18/2024 suffering is a subjective experience, as is fear of anticipated suffering. Different people experience suffering or fear of suffering in different ways, and hence it is only the individual who can determine whether they believe they can bear the suffering - the doctor cannot do this for them.

165. That said, whilst the assessing doctor must set aside their own beliefs as to whether the individual can bear the suffering, Article 29 nevertheless requires the assessing doctor to tell the individual if they, the assessing doctor, disagrees with the individual's belief that they would not be able to bear expected suffering.

166. This requirement for the assessing doctor to tell the individual that the assessing doctor thinks the individual's belief is wrong was not set out in P.18/2024. It has been added further to stakeholder feedback.

Capacity (Article 26)

167. In order to be eligible for an assisted death, the individual must have capacity to decide to end their life by assisted dying. Article 26 sets out a specific assisted dying capacity test, which focuses on all relevant decision-making factors, rather than relying on the more general capacity test set out in the Capacity and Self-Determination (Jersey) Law 2016 ("CSDL"). The assisted dying capacity test states that the doctor must be satisfied that the individual has the capacity to:
    a. receive the information given to them
    b. understand the information and all matters relevant to their decision, including the effect of their decision - i.e., that it will result in their death
    c. retain the information for long enough to make their decision
    d. use or weigh the information in making their decision or request
    e. convey their decision.

168. The draft law, like the CSDL, requires any decision that the person lacks capacity to be based on evidence that they lack capacity, as this is critical to ensuring proper respect for personal autonomy. This is known as a 'presumption of capacity' – i.e., capacity is presumed unless there is evidence of lack of capacity, as distinct from "capacity has to be evidenced". This accords with assisted dying laws in other jurisdictions.

169. However, the presumption of capacity in the assisted dying law is different to the CSDL, in that under the assisted dying law the doctor must be satisfied that the person meets the capacity test, and they only assume the person has capacity (i.e., the capacity to weigh up and use information to make an assisted dying decision as per the capacity test) if, in working to satisfy themselves, they cannot evidence the person does not have that capacity – i.e., they cannot assume capacity at the outset on the basis that there is no evidence of lack of capacity.

170. Note: the CSDL is also different from the assisted dying law in that, under the CSDL law if it is determined a person does not have capacity, a 'best interests decision' may be made on their behalf – i.e. a doctor may decide the person should be given a treatment they have refused. Under the assisted dying law, no-one may decide that an individual may have an assisted death, except that individual.

Individual's decision or request is voluntary, clearly expressed and settled (Article 27)

171. During the first and independent assessments (Step 2 and 3), care planning (Step 6) and final request and review (Step 7), the assessing doctors and administrating practitioners must be satisfied that the individual's decision to end their life by assisted dying is voluntary, clearly expressed and settled. They must also believe the individual's request is:
    a. voluntary and clearly expressed whenever the individual requests to proceed to the next step of the process
    b. settled when the individual requests to moves from Step 4 to Step 5 of the process (i.e. that their wish for an assisted death has been maintained from the point at which they made their first request to the point at which the Coordinating Doctor approves that requests)

172. In determining the voluntary nature, the doctor must talk to the individual about:
    a. why they wish to end their life by assisted dying
    b. whether anyone has asked, coerced or pressured them, or they have felt coerced or pressured, to request assisted dying.

173. In determining whether the decision or request is clearly expressed and settled the doctor must talk to the individual about:
    a. why they wish to end their life by assisted dying
    b. how long they have had that wish
    c. whether their wish is consistent or changing.

174. They may seek relevant opinions of others – for example a social worker from the extended team.

Individual's decision or request is informed (Article 28 and 29/ Schedule 1)

175. The draft law requires an individual's decision to have an assisted death to be an informed decision, and sets out the information that must be provided to the individual. This includes both:

    a. the general information set out in Schedule 1 which includes information about:
        - the criteria for assisted dying
        - each step of the assisted dying process (this will include information on minimum timeframes - see paragraph 64)
        - the Service
        - the right to appeal certain decisions under this Law
        - how they or their family and friends may obtain support (such as counselling)

- how someone may complain about service
- matters that an individual may want to consider before their death (such as life insurance or other personal administrative or financial matters)

b. the specific information set out in Article 29 which includes information as it relates to their personal circumstances. This includes information about:
   - the physical condition that is expected to cause their death; the expected course of the condition; options for care and treatment and the likely outcomes
   - options for the administration of the approved drugs and any associated risks (including whether it is self-administration or practitioner administration, and the method of administration – oral, IV etc)
   - options for the place of their assisted death
   - the involvement of family or friends in the carrying out of the assisted death, and the risk to those people (for example, any distress they may experience as a result of supporting, or not supporting, self-administration)
   - the individual's choice to do any of the following, and the implications of each choice: consent to the continued carrying out of the assisted death; waive the requirement for future capacity; or to decide in advance to refuse treatment (see paragraphs 94 - 96)
   - the individual being able to withdraw their request for assisted dying during the process
   - on the requirement for the individual to request to proceed to taking the next step in the process
   - matters that the individual must decide including, talking to their family members or friends about their request for assisted dying (unless the assessing doctor believes that it is not reasonable to do so, after discussing the individual's circumstances with them) and whether they want other practitioners to know about their request (for example, their domiciliary care provider).

176. Critically, the individual must also be informed, and must understand, that they are expected to die if approved drugs are administered.

177. In addition to the draft law requiring the provision of the information set out above, the assessing doctors must be satisfied that the individual has understood the information.

Residency (Article 30)

178. As set out in paragraph 42, the individual must be ordinarily resident in Jersey for 12 months immediately prior to making their first request for assisted dying and continue to be resident throughout the assisted dying process. Hence residency is assessed throughout the assisted dying process.

179. Article 30 provides however, that once the Coordinating Doctor has determined the individual meets the residency criterion at Step 1, an assessing doctor or Administering Practitioner can, at all other steps, be satisfied that the individual is resident providing the individual confirms they continue to be resident and there is no evidence to the contrary.

Relevant opinions of others (Article 31)

180. Article 31 accords with the proposals set out in P.18/2024, albeit relevant opinions were referred to in P.18/2024 as *supporting opinions or assessments*. Article 31 provides for matters related to the relevant opinions that an assessing doctor or administrating practitioner must seek, if necessary to deciding a matter (for example, they must seek relevant opinion from social worker if determining matters related to potential coercion) or may seek if helpful to understanding a matter (for example, opinion from a family member about the individual's suffering).

181. Relevant opinions may be required when determining an individual's eligibility for assisted dying or when considering other matters such as the requirement for communication support or advocacy support.

182. The draft law allows for relevant opinions because, at set out in P.18/2024, it must be recognised that assessing doctors may not have expertise on all conditions (and associated treatments) so must be able to seek that expertise as required.

183. The draft law provides that the assessing doctor or an Administering Practitioner may seek the opinion of persons whom the doctor or practitioner thinks will help them decide or form their belief about a matter. This may include:
    a. connected persons - a person who has a personal relationship with an individual, such as a family member, friend, neighbour or colleague, or
    b. professionals who have the required expertise or experience. This may include professionals who are not assisted dying practitioners or extended team members.

184. A relevant opinion may not be sought unless the individual has given their permission for information to be shared at Article 14.

185. A professional providing a relevant opinion:
    a. may have previously seen the individual in a professional capacity (for example, their palliative care consultant) or may not have any previous knowledge of the individual (for example, a mental health practitioner may be asked by an assessing doctor to assess or examine the individual and advise on their capacity)
    b. may be asked to examine or assess the individual or may be asked to provide general information about life expectancy, prognosis or treatments associated with specific conditions in which they have expertise.

186. The assessing doctor / Administering Practitioner must tell the professional that their opinion relates to a request for assisted dying and the professional may exercise their right to refuse (Article 36).

187. As set out in P.18/2024, where a professional opinion is sought, the doctor or Administering Practitioner must have regard to the opinion but they are not required by law to agree with the opinion or base their decision on that opinion. It is the assessing doctor or Administering Practitioner who is responsible for the determination of eligibility, and they must rely on

their own determination (whether or not informed by the relevant opinion). It is common practice for doctors, who are trained to use their professional judgement, to make determinations that do not accord with the opinions or determinations of all other professionals. However, the operational guidance will state that where they do not adopt the relevant opinion, they must have clear and robust reasons for doing so and this must be documented in the relevant forms.

188. For the purposes of clarity, the professional providing the relevant opinion will not be making an explicit determination of eligibility for assisted dying. They will instead be providing their opinion on matters which they are qualified to assess, determine or advice on (for example, disease progression or treatment) for the assessing doctor or Administering Practitioner to determine the matter at hand.

Second opinion request (Article 32)

189. As set out in P.18/2024, an individual may request a second opinion assessment if they are found not to meet any of the main criteria either during the first assessment or independent assessment. Whilst P.18/2024 indicated this would be a matter for guidance, the main criteria include the health, capacity and decision-making criteria but does not include the age or residency criteria, although age and residency may be subject to appeal (Article 42– see paragraphs 232 -243).

190. A second opinion may only be requested by the individual. A third party (for example, a family member, an attending practitioner or carer) cannot request a second opinion if they are in disagreement with the assessing doctor's determination that the individual does, or does not, meet the criteria.

191. Where a third party has a concern about an assessing doctors' determination, they may raise that concern through the complaints process. (Note: the Committee is required at Article 61 to arrange for the development of procedures for investigating and resolving complaints). It is anticipated that the complaints process will set out that, in the first instance, the third party should raise their concerns with the Coordinating Doctor, who must give the matter their consideration, unless the complaint is about that doctor, in which case it will escalate in accordance with the complaints policy. This is a minor variation on P.18/2024 which proposed that the draft law would place a duty of the Coordinating Doctor to consider complaints. On further consideration, and in discussion with stakeholders, it has been determined that a statutory duty should not be placed on the Coordinating Doctor because the complaint which may be about that doctor's decisions.

192. As noted in P.18/2024, an individual should not be provided an automatic right to a second opinion because of the potential for second opinions assessment to result in a vexatious use of resource if an individual, who is clearly not eligible for an assisted death, requests multiple second opinions. The draft law addresses this be providing that, whilst an individual may request a second opinion, that request must be reviewed by a 'review doctor' who must determine whether to accept or reject the second opinion request.

193. The review doctor is an assisted dying practitioner who is registered with the Service and who has not previously been involved in the individual's assisted dying process.

194. In deciding whether to accept the second opinion request, the review doctor:
   a. must review the forms from the original assessment/s
   b. may review the relevant opinions of others (if any)
   c. may discuss the matter with the individual, the assessing doctor or any individual who provided a relevant opinion.

195. The review doctor must accept the second opinion request if they consider it reasonable to think that the results of the original and second opinion assessments may differ. If not, they must refuse the second opinion request. If they refuse the request, the individual must be told the reasons why, in person and in writing. If they accept the request, a second opinion assessment will be arranged.

196. A person may request a second opinion at both the first and second assessment, because there may be valid reasons for requesting a second opinion at each stage of the process.

Second opinion assessment (Article 33)

197. The Second Opinion Doctor must be an assisted dying practitioner but cannot be the individual's Coordinating Doctor or Independent Assessment Doctor.

198. The Second Opinion Doctor:
   a. must review the assessing doctor's form from the original assessment and the relevant opinions of others (if any) and,
   b. may themselves assess the individual.

199. Whilst the draft law does not prevent the Second Opinion Doctor from determining that the eligibility criteria are not met based on a review of the assessing doctor's forms and any relevant opinions, it does require the Second Opinion Doctor to meet with the individual and undertake their own assessment to satisfy themselves that eligibility criteria are met. This provision allows for the Second Opinion Doctor to reasonably and appropriately exercise their clinical judgement based on an evidence review when determining criteria are not met but provides for additional safeguards are when determining that the criteria are met.

200. The Second Opinion Doctor may determine any unassessed criteria from the original assessment (see paragraph 59) in addition to unmet criteria from the original assessment.

201. Having undertaken their assessment, the Second Opinion Doctor must notify the Coordinating Doctor of their findings, who must inform the individual that the Second Opinion Doctor:
   - is satisfied that the individual meets the criteria and may proceed to the next step; or
   - is not satisfied that the individual meets the criteria, specifying which criteria are met, unmet or unassessed and the associated reasons.

Prescribing, preparing and dispensing approved drugs (Article 34)

202. As described in P.18/2024, it is important to ensure a clear chain of control over the approved drugs. For this reason, the draft law provides that the approved drugs may only be prescribed by the individual's Administering Practitioner or another assisted dying practitioner who is acting for the individual's Administering Practitioner.

203. This is in addition to the approved drugs only being prepared and dispensed by a Pharmacy Professional at the Jersey General Hospital and may only be dispensed to the Administering Practitioner or another assisted dying practitioner at their request.

204. Article 62 provides that the Committee must produce operational guidance on the prescribing and dispensing of approved drugs.

Change of practitioners (Article 35)

205. As set out in P.18/2024, the draft law provides that any assisted dying practitioner (for example, a Coordinating Doctor or a certifying doctor) may be replaced at any time in the process if required. For example:
    a. if a Coordinating Doctor makes a declaration of interest that the review officer determines would impact on their ability to perform the role
    b. if a Second Opinion Assessment determines that the person has met the eligibility criteria, in which case the Coordinating Doctor may not wish to continue in the role and the Second Opinion Doctor may agree to assume the role of Coordinating Doctor
    c. if an unforeseen circumstance occurs, such as long-term sickness or unplanned absence, which means the practitioner cannot continue in role.

206. Any practitioner would be replaced by an equivalent practitioner (for example, a Coordinating Doctor would be replaced by another Coordinating Doctor).

207. The draft law requires the practitioner or doctor who is being replaced must tell the individual about the change as soon as reasonably practicable.

208. **Safeguards**

The provisions set out in Part 2 of the draft law (as described above) and the governance and oversight arrangements set out in Part 3 of the draft law (as described below) provide a robust framework of controls which support compliance with the following five key safeguarding objectives:

a. only those who meet the eligibility criteria are approved for an assisted death

b. all islanders are protected and supported throughout the assisted dying process, including:
    - Islanders who may be coerced or pressured into requesting assisted dying
    - people with mental health conditions and / or those who do not have decision-making capacity

- family members and loved ones of the individual requesting an assisted death
- continuing ongoing support, care and treatment for individual whilst requesting an assisted death and on the assisted dying process

c. assisted dying practitioners act in accordance with guidance and law

d. professionals are supported and protected when acting in accordance with guidance and law, regardless of their position on assisted dying

e. The Assisted Dying Service is safe and of high quality.

Appendix 5 provides details of safeguarding associated with the five safeguarding objectives.

Section 4: Part 3 of the draft Law - right to refuse, protections, challenging decisions, offences, committee, service and review panel

209. Part 3 of the draft law sets out matters relating to:
   a. right to refuse, safe access zones, disclosure of information and appeals
   b. protection and offences
   c. Assisted Dying Assurance and Delivery Committee
   d. the Assisted Dying Service
   e. Review Panel.

Right to refuse to participate and associated protections (Articles 36 – 39)

210. In accordance with P.18/2024 the draft law provides all persons with a right to refuse to participate in assisted dying for any reason. For example:
   a. on moral, ethical or religious grounds (conscientious objection)
   b. because of professional's concern about the potential emotional impact on themselves of participating in an assisted death
   c. for practical or business reasons (concern that their participation may create concerns amongst other clients or patients).

211. There are a few limited exceptions to the right to refuse to participate:

   a. an assisted dying practitioner, a Certifying Doctor and a Care Navigator cannot refuse to participate on the basis that they have opted-in to be an assisted dying practitioner

   b. an administrating practitioner cannot refuse to administer the approved drugs to the individual (as distinct from supporting the individual to self-administer) if the Administering Practitioner previously agreed to do so - but they may refuse to agree to do so in the first instance (see paragraph 88). This is to avoid undue distress to an

individual if an Administering Practitioner were to unexpectedly exercise their right to refuse in the hours and minutes immediately preceding death

c. a witness to the administration of the drugs (at Step 7) cannot refuse to witness the administrating practitioner administer the approved drugs to the individual if the witness previously agreed to do so. As above this is to avoid undue distress in the hours and minutes immediately preceding death.

212. In accordance with the Panel's amendment to P.18/2024 (as adopted) the draft law does not limit the right to refuse to direct participation in assisted dying, as distinct from indirect participation, but in common with other Assisted Dying Laws (Victoria and Western Australia[17],[18]) it does set out activities that:

a. constitute participation, so may be refused (for example, giving patients information about assisted dying; giving a relevant opinion to support an assisted dying assessment; being present at the administration of the approved drugs)

b. do not constitute participation, so may not be refused (for example, caring for the individual's body after death; reserving an appointment time for them; providing usual care and treatment; cleaning the Services offices).

213. **Exercising right to refuse**

The right to refuse includes the right not to give someone information about assisted dying if they have asked for it, or if they are being given information about how their condition may be treated. However, in exercising that right a health care professional, the draft law sets out that must tell the person

- they are exercising the right to refuse
- that the Service may be able to help the person
- how the person may find the Service's contact details.

The requirements set out above mirror those set out in professional regulatory standards, such as the GMC's guidance on ethical objections.

The draft law sets out there must be operational guidance to support all professionals to operate within the right to refuse provisions set out in the draft law (Article 62), plus the appropriate conversations training to be developed by the Committee must also address the right to refuse (See paragraph 260)

[17] Voluntary Assisted Dying Act 2017 (legislation.vic.gov.au) – Article 7
[18] Voluntary Assisted Dying Act 2019 - [00-00-00].pdf (legislation.wa.gov.au) – Article 9

In addition, as set out in P.18/2024, it is anticipated that the Service will provide all health care professionals with information leaflets that they may hand to patients who have raised the subject of assisted dying. The monies required for this have been factored into the resource requirements set out in Section 6 of this report.

214. In accordance with feedback from the BMA, and in common with legislation in New Zealand[19] and the Isle of Man[20], the draft law protects employees and business partners (for example, partners in a GP Practice) who exercise their right to refuse, from employment detriments, such as being sacked, overlooked for employment, promotion etc. Equally, it also protects employees and business partners who do participate in assisted dying.

215. Article 96 enables the Assembly, by Regulations, to provide for civil remedies where an employee or business partner has suffered an employment detriment because they refused to participate or did participate in assisted dying. It is anticipated that the Minister will present these Regulations to the Assembly before the law comes fully into force (see paragraph 309 & 312).

216. Article 39 also protects tenants who refuse to participate, or conversely do participate, in an assisted death. This includes tenants:
   a. whose housing is related to their employment
   b. tenants whose landlord holds a position on assisted dying (for example, a faith based housing association)
   c. tenants who wish for their assisted death to take place at home, where that home is rented.

217. P.18/2024 proposed that a landlord could not prevent a tenant from having an assisted death in home but, following discussion with stakeholders, the provisions set out in the draft law have been cast wider so as to include other categories of tenants (such as those referenced in the above paragraph).

218. **Discussion of assisted dying with patients**

In accordance with P.18/2024, the draft law is 'silent' on health care professionals discussing assisted dying with their patients (except where the health care professional is exercising their right to refuse). That is to say, the law will neither:

a. require health and care professionals to raise the subject of assisted dying with a patient whom the professional thinks may be eligible for an assisted death, nor

b. prohibit health and care professionals from talking to their patient about assisted dying, in the context of the patient's care and treatment options, even where the patient did not raise the subject in the first instance.

[19] End of Life Choice Act 2019 No 67 (as at 28 October 2021), Public Act 8 Conscientious objection – New Zealand Legislation
[20] Assisted Dying Bill 2023

Whilst assisted dying should never be 'recommended', health and care professionals do need to be able to engage in open and informed conversations about end-of-life options which may, in some cases, include assisted dying. There is a balance to be struck between:

a. the risk that a patient may feel that assisted dying is being suggested to them as a preferred option
b. the risk that a patient is unable to have an informed discussion with a trusted professional about their end-of-life options, and
c. the risk that access to information is inequitable.

The draft law sets out there must be operational guidance to support all professionals – not just assisted dying practitioners - to have appropriate conversations with patients about assisted dying (Article 62) and associated training (Article 66). In providing this training, the draft law is clear that there is no compulsion for other professionals to attend, for example, if they object to assisted dying.

Safe access zones (Article 40)

219. A safe access zone is a designated area in which protests, demonstrations and other activities are expressly prohibited. They are intended to protect professionals and service users from potential harassment and/or abuse. Safe access zones are provided for in abortion in the UK and other jurisdictions.

220. The draft law provides that certain activities will be banned in safe access zones and that the Assembly may, by regulations, specify what activities are banned, in addition to designating the associated safe access zone boundaries and time periods.

221. It will be an offence for a person to undertake an activity that is banned by Regulations (for example, physically obstructing someone's access to the Service, or harassing them).

222. The UK Supreme Court[21] held that safe zones around abortion clinics are compatible with the Human Rights Convention, with much of the associated reasoning being applicable to assisted dying safe zones. Whilst safe access zones do place some narrow restrictions on rights related to freedom of expression (to protect individuals from harassment) they do not breach the Convention because they do not fundamentally undermine the right to freedom of expression.

223. It is intended that safe access zone Regulations will be brought to the Assembly before the draft Law is fully enacted, following a period of public consultation.

[21] Judgment in *Reference by the Attorney General for Northern Ireland - Abortion Services (Safe Access Zones) (Northern Ireland) Bill* [2023] AC 505 §§113-117-155

224. Note: is it also envisaged that safe access zones will also be provided for in the amended termination of pregnancy law to be lodged in December 2025.

Disclosure of information about people (Article 41)

225. The draft law prohibits people from disclosing information that allows for the identification of an individual who is having an assisted death or a professional who is involved in an individual's assisted death. It further prohibits disclosure of information about an individual's assisted death.

226. There are exceptions to these prohibitions, for example, the individual having the assisted death or their family members may talk about it, do media interviews etc providing they do not disclose information about the professionals involved (unless those professionals give their permission).

227. Information may also be disclosed to protect a person's safety (for example, whistleblowing) or to support an investigation into a professional's practice.

228. Article 52 provides that it will be an offence to disclose this information in a manner which does not accord with the law.

229. In prohibiting the disclosure of information about an individual, it is nevertheless the case that, as set out in P.18/2024, Medical Certificate of Fact and Cause of Death[22] and the register of deaths – which is a public document - will include details of antecedent causes of death, amongst other matters. Hence, the names of people who have had an assisted death will be a matter of public record post death (see paragraph 117).

Disclosure of information about the approved drugs (Article 41)

230. The draft law similarly prohibits people from disclosing information about the approved drugs, except that the Administering Practitioner may tell the individual about the approved drugs to be used for their assisted death. Information about the approved drugs will not be published due to the sensitivity of the information.

231. Article 41 provides that it will be an offence to disclose information about the approved drugs in manner which does not accord with the law.

Appeals (Article 42)

232. In accordance with P.18/2024, the draft law provides for appeals to the Royal Court. Whilst most jurisdictions do not provide for appeals within their assisted dying legislation (an exception being some Australian states), the Assembly previously determined that a right of appeal was important to support public confidence in the assisted dying process.

233. Appeals will be made to the Royal Court, which will sit as the Inferior Number - this will consist of the Bailiff, Deputy Bailiff or a Royal Court Commissioner sitting with two Jurats.

[22] as required under Article 64 of the Marriage and Civil Status (Jersey) Law 20011 ("the 2001 Law").

As opposed to the Superior Number which consists of the Bailiff, the Deputy Bailiff or a Royal Court Commissioner and a minimum of five Jurats.

234. The draft law provides that an appeal against a decision must be made within 28 days of that decision being made by the assisted dying practitioner.

235. An individual may appeal a decision that their request for assisted dying is rejected, at any step in the process, on the basis that:

a. (in respect of the health criteria), the decision was irrational or not made in accordance with the law; or
b. (for any other decision), the decision was unreasonable, or not made in accordance with the law;

236. A person with a special interest in the care and treatment of the individual requesting an assisted death may only appeal the Coordinating Doctor's decision to approve the individual's assisted dying request at Step 5, on the basis that:

a. (in respect of the health criteria), the decision was irrational or not made in accordance with the law; or
b. (for any other criteria), the decision was unreasonable, or not made in accordance with the law.

237. It is for the Court to be satisfied whether a person has a special interest. This may be, for example, a family member or a professional involved in the individual's assisted dying process. It does not include an unconnected third party (such as a representative of a lobby group) who is appealing a decision of the Coordinating Doctor on the basis that they do not support assisted dying.

238. P.18/2024 set out that the grounds for appeal would not include matters relating to health criteria (i.e., the individual's diagnosis and prognosis or their beliefs related to their suffering / anticipated suffering). In discussion with law officers this position has been amended. The draft law now provides that the individual / person with a special interest may appeal a decision on the health criteria decision but only if that decision is irrational (i.e. a decision that is flawed or so unreasonable that it could not be sensibly reached) or not made in accordance with the law.

239. A health criteria decision cannot be appealed on the grounds of difference of opinion alone, where the opinion is reasonable and made in accordance with the law. For example, if an assessing doctor is of the opinion that the individual's life expectancy is 8 months, and that opinion is supported by medical literature and by other medical professionals who have examined the individual, the individual cannot appeal on the grounds that they think their life expectancy is 5 months.

240. The draft law (Article 9) sets out that minimum timeframe between assisted death being approved at Step 5 and taking place at Step 7, must be at least 2 working days. This 2 working day period allows for an appeal by person with a special interest.

241. It is acknowledged that 2 working days is a limited period, but it strikes a balance between giving time for appeals, whilst not significantly impeding the assisted dying process where the individual wishes to proceed.

242. It is further acknowledged that a person with a special interest can only appeal if they are aware of the individual's assisted dying request in the first instance. This may not always be the case, despite the draft law providing that the assessing doctors must advise the individual to speak with family and friends about their assisted dying request (Article 29).

243. The 2 working day minimum timeframe may be overridden but only an assessing doctor (or another doctor, as permitted by the draft law) is satisfied that the individual's life expectancy is 14 days or less (Article 7).

Protections and offences

Protections (Article 43)

244. The draft law states that assisted dying is not suicide. This accords with the principles set out in P.18/2024 and provides that a person who is lawfully engaged in supporting an individual's assisted dying process in Jersey is not aiding or abetting suicide.

245. The draft law then provides that a person who is authorised by the assisted dying law to perform an assisted dying function, does not commit an offence under another law if they perform the function in good faith and in a way they reasonably believe to be in accordance with the draft law and cannot be held liable in a civil court or disciplinary proceedings if they also do so with reasonable skill and care. The effect of this provision is that, for example:

a. an administrating practitioner is not committing the offence of homicide if they administer the approved drugs to bring about an individual's death, providing they are a registered Administering Practitioner and providing all provisions of the law are accorded with

b. any other person who administers the approved drugs to an individual is committing an offence even if the individual wanted the other person to assist in ending their life.

246. Clarification of matters related to suicide

As noted in P.18/2024, there is currently some lack of clarity as to the legal provisions associated with suicide and assisting suicide in Jersey law. Suicide was historically treated as a crime in Jersey under customary law, but practice has evolved and the Courts have ceased treating suicide as a crime.

Whilst the Homicide (Jersey) Law 1986 refers to the "offence" of "aiding, abetting, counselling or procuring a person's suicide," it is doubtful whether that wording serves to create an offence, and whether there can be an offence of "aiding, abetting" etc. if suicide itself is no longer an offence.

This has been addressed via consequential amendments to the draft law which clarifies that:

a. suicide (taking one's own life) is not an offence.

b. an act that is capable of encouraging or assisting the suicide or attempted suicide of another person is an offence, if the act was intended to encourage or assist suicide or an attempt at suicide (such an offence would be broadly in-line with section 2 of the UK's Suicide Act 1961).

Offences (Articles 45 – 53)

247. In jurisdictions where assisted dying is permitted, there are two broad approaches to offences under the law:

Approach 1: assisted dying is treated in law as an exception to existing criminal offences such as homicide, i.e., a medical practitioner who supports a person's assisted death would not be committing the offence of homicide if the assisted death complied with the assisted dying law. This is the approach in the Netherlands, Belgium and Luxembourg.

Approach 2: this similarly treats assisted dying as an exception to existing criminal offences but also creates new offences to protect against the wider public. This is the approach used in most other jurisdictions (Canada, New Zealand, all Australian states) and is the approach taken in the draft law.

248. The draft law provides the following offences in accordance with P.18/2024. It is an offence:

a. to unlawfully administer, or assist in the administration or self-administration of, the approved drugs unless in accordance with the law

b. to coercively or dishonestly induce a person to request an assisted death, or decide to end their life by assisting dying, or conversely to withdraw their request for an assisted death

c. to give a false or misleading statement or forge a document, which would include the individual, their friends or family giving false information to an assisted dying practitioner or assisted dying practitioner giving false information, including as part of the assisted dying registration process

d. not to tell the Service about significant registration matters i.e., an assisted dying practitioner commits an offence if they do not tell the Service, for example, if their professional registration as a doctor (whether in Jersey or the UK) has been cancelled, suspended, or had conditions imposed

e. to disclose information that they are prohibited from disclosing, for example, information that allows for identification of an individual, the assisted dying practitioners involved in an individual's assisted dying process, or the approved drugs (see paragraphs 225 - 231).

249. In addition, the draft law also provides that it is an offence to:

a. purport to act as an assisted dying practitioner, Certifying Doctor, or Care Navigator – i.e., to undertake the duties for one of these professionals when not registered to undertake the roles

b. purport to be an assisted dying practitioner, Certifying Doctor or Care Navigator – i.e. to falsely pretend to hold one of these roles or allow another person to state they hold that role

c. purport to be the Assisted Dying Service or to provide assisted dying - i.e., an organisation or person cannot state they are the Assisted Dying Service or that they provide assisted dying when they are not the Assisted Dying Service, or allow another person to state they are the Service

d. promote or advertise assisted dying with the intention of persuading or encouraging anyone to have an assisted death although this offence does not prevent people from giving information about assisted dying for legitimate purpose, such as the Government of Jersey website providing information about the Service, or a GP telling people they are also an assisted dying practitioner.

250. The offences above are introduced to safeguard against people being misled or scammed by third parties seeking to generate income (for example by offering a paid for assisted dying pre-assessment process) or for other such purposes.

251. In addition, as set out in paragraphs 219 - 224, it is an offence to do banned activity in a safe access zone and in accordance with Regulations made by the Assembly.

Assisted Dying Assurance and Delivery Committee (the "Committee")

Committee members (Article 54)

252. The draft law provides that the Minister must establish and maintain an Assisted Dying Assurance and Delivery Committee ("the Committee") to undertake the functions and obligations set out below. Committee members will include:

a. the Chair – a person who has experience of supervising and assuring the provision of health and care services to patients and is neither an employee or governor / trustee of an organisation that provides palliative or end-of-life care in Jersey or directly affiliated with a group that campaigns for, or against, assisted dying

b. regular members – who may be:
   - representatives of palliative or end-of-life care services providers in Jersey (excluding HCJ employees)
   - people with significant experience in supervising and assuring provision of health and care services (excluding HCJ employees)
   - people who represent patients and who have experience of palliative or end-of-life care in Jersey themselves or as provided to a family member or friend
   - experts in medical ethics
   - any other person who has experience that the Minister considers to be relevant

c. professional lead members – senior HCJ professionals who have responsibility for other professionals and expertise in governance, professional practice and standards, for example, the Chief Officer, the Chief Nurse, the Medical Director.

253. The Minister will appoint:
   a. the Chair having consulted the Jersey Appointments Commission.
   b. the regular members, having consulted the Chair and the Jersey Appointments Commission, if the Minister deems it appropriate to consult the Jersey Appointments Commission.

254. There is no absolute duty to consult the Jersey Appointments Commission when appointing regular members on the basis that the number of potential candidates is limited and that the Chair, who must be consulted by the Minister, can provide appropriate advice and guidance.

255. The Chair may appoint the professional lead members.

256. The Minister may choose to remunerate members (except professional lead members) and must repay reasonable expenses (see Article 56).

257. The draft law does not provide the periods of appointment, which will accord with the policies of the Jersey Appointments Commission, nor does it provide for grounds of dismissal of the Chair and regular members. These will be provided for in the Committee's terms of reference and associated contracts for service.

Terms of reference (Article 55)

258. The Committee must work in accordance with its terms of reference, which must be approved by the Minister. The terms of reference will set out the Committees procedures for performing its functions and obligations, for example, matters related to the holding for Committee meetings, resolution of conflicts of interest, etc.

Functions and obligations (Article 57 to 70, Article 76 and Article 91)

259. The Committee must ensure that the Service operates in accordance with the assisted dying law and the Regulation of Care (Jersey) Law 2014, and has regard to the assisted dying operational guidance (Article 57).

260. The Committee must arrange for the development, maintenance, and approval of the following policies, systems, procedures, guidance, and support services. This includes determining whether they should be published (under Article 68) or only made available to relevant people such as regulators or professionals (under Article 69). In arranging for their development, the Committee must ensure that any consultation requirements set out in the draft law are complied with. The policies, systems, procedures, guidance, and support services include:

a. the schedule of approved drugs (Article 58)

b. the assisted dying individual's record system and associated retention schedules. The individual's record system which holds all records, forms and details related to an individual who has request an assisted death, whether or not they had an assisted death (Article 59 and Article 61). Assisted dying practitioners and care coordinators working for the Service will ensure all records and forms are held in the system, with the Service permitting access to the record in accordance with Article 79 of the draft law (for example, providing records to the Review Panel)

c. the register of assisted dying practitioners and certifying doctors which records each person who is an assisted dying practitioner and the assisted dying role they may undertake. In accordance with P.18/2024 that register will not be a public register to protect the privacy of practitioners in a small jurisdiction. This decision was taken in consultation with the UK professional regulatory bodies (Article 60). The Committee must also ensure that the Service registers professionals in accordance with the requirements of the draft law (see paragraphs 285 - 292)

d. the general information about the assisted dying process as set out in Schedule 1 of the draft law. This includes information about the criteria; the process; the Service; appeals; access to support services for the individual, family and friends, and professionals; complaints and matters that an individual may want to consider before their assisted death, such as life insurance or other personal administrative or financial matters (Article 61 and Schedule 1).

An assessing doctor must be satisfied that an individual's decision, or request, to have assisted death is informed, hence Article 28 of the draft law places a duty on the assessing doctor to ensure the individual has been provided the general information, and to be satisfied that the individual has understood the general information.

e. Assisted Dying Service standards and procedures for investigating and resolving complaints

f. the operational guidance which sets out how a professional must comply with the draft law or provides details as to how they carry out a particular function. Non-compliance with operational guidance is not a breach of the law, but it may be used as evidence in prosecution or disciplinary proceedings. Operational guidance must include:

- the right to refuse to participate in assisted dying
- having appropriate conversations with patients about assisted dying
- holding, indexing, and giving access to individuals' records
- registration of assisted dying practitioners
- places of assisted deaths
- independent advocacy, communication support, and support for interpretation of languages and advocacy
- assessing individuals for assisted dying
- care planning
- prescribing and dispensing approved drugs
- administering approved drugs, including protocols for medical complications
- disclosing interests and deciding whether they conflict
- disclosing information about health professionals to regulatory bodies
- donating organs - as set out in P.18/2024, the draft law does not prohibit post-assisted death organ donation, but it is intended that guidance will be developed in consultation with the NHS Blood and Transplant Authority. In many cases, the physical conditions that make a person eligible for an assisted death rule out the possibility of donation in any event as the organs are no longer viable (for example, cancer)

g. general guidance for people who are not health and care professional. The family and carers guidance (required under Article 63) will set out easy to understand information on matters such as how to support a family member who is requesting assisted dying; how to access support services; how to notify the Service if a loved one wants to withdraw their request; how to appeal or raise a complaint

h. the professional competencies required to be an assessing doctor, Administering Practitioner, Pharmacy Professional, extended team member, or certifying doctor. (Article 80 provides that a professional cannot be registered with the Service unless they meet the competencies). The competencies, which will be developed in consultation with relevant UK professional bodies, must consider the following:

- capabilities, including professional skills (for example, practical, communication and clinical skills), professional knowledge and professional values and behaviours (for example, professional and ethical responsibilities and safeguarding vulnerable patients)
- training, in addition to the mandatory assisted dying training

- professional qualifications
- requirements to be professionally registered (for example, requirements of an assessing doctor to be registered with the Jersey Care Commission and the GMC, including the minimum period for which they must have been registered).

i. training for assisted dying professionals which must be completed by all assisted dying practitioners, Certifying Doctor and Care Navigators. This includes initial training that is required before registration with the Service, and continuing training at intervals set by the Committee. (see Article 65)

The training must be relevant for each assisted dying role and must include:

- all elements of the law, including the assisted dying process and assessment requirements
- operational guidance
- risk
- domestic abuse and whether someone has been coerced or pressured to do something, including coercive control and financial abuse
- the safety and well-being of professionals
- the technical knowledge required to perform each role (e.g.: administration of approved drugs by an Administering Practitioner; certification of an individual's assisted death by a certifying doctor)

j. other training which may be completed by anyone who provides health and care services in Jersey (if they wish to complete the training), and which must include training on appropriate conversations (Article 66)

k. support for individuals, family and professionals (such as counselling) to help the person deal with any negative effects of their involvement in the assisted dying process or their bereavement (Article 70).

261. In addition to above, Articles 71 and 72 provide that the Committee may investigate the practice or performance of assisted dying practitioners, certifying doctors or care navigators in accordance with Regulations made under the Law. The purpose of these investigations is to consider whether disciplinary proceedings may be required by an employer or regulatory body, or in enforcement or prosecution purposes. Any disciplinary proceedings could result in suspension or cancellation of the professional's assisted dying registration.

262. The Committee must, in accordance with Article 91, develop the terms of reference for the Assisted Dying Review Panel ("the Panel") for approval by the Minister. The terms of reference will set out how the Panel will perform its functions (for example, how the Panel makes decisions and resolves conflict). See paragraph 296

263. In relation to assuring compliance with the law and operational guidance, the Committee must (in accordance Article 76) consider the decisions, findings and recommendations

made by the Assisted Dying Review Panel under Article 94 or 95 (see paragraphs 296 - 303 below). The Committee may accept and act on a Review Panel recommendation or may reject a recommendation and take a different course of action. In all cases, it must send a copy of the Panel's report to the Care Commission with details of any action the Committee proposes to take.

264. As described in paragraph 301 below, the Review Panel must undertake review of every assisted death in Jersey ("post-death review"). The Committee may, however, request that the Panel also review an assisted dying process that ended before an individual's assisted death (for example, the individual withdraw their request; the request was not approved; the person died of natural causes). If the Committee requests a review of an incomplete assisted dying process, the Panel must undertake that review.

Reports of the Committee (Article 73 to 76)

265. The draft law provides that the Committee must collect and analyse information to:
    a. identify any trends or issues with assisted dying, for example, whether requests for assisted dying by individuals with similar conditions indicates a problem with treatment or care for the condition
    b. assure the quality and safety of the Assisted Dying Service.

266. This must include information about:
    a. individuals who request assisted dying and the outcome of their assisted dying process
    b. the Service's compliance with the law, operational guidance and service standards
    c. the investigation and resolution of complaints.

267. The Committee must report the following information to the Minister and to the Jersey Care Commission on an annual basis:

    a. the numbers of:
        - first requests
        - individuals whose requests is approved
        - individuals who withdrew their request and at which step in the process
        - individuals who died from an assisted death, including how the approved drugs were administered and whether they were administered by the practitioner or the individual
        - assessments for each individual at each step in the process, including second opinions and relevant opinions from professionals
        - appeals, the grounds for appeals, and the outcomes

    b. for each individual to whom approved drugs were administered:
        - the period between the approval of their request for assisted dying and their assisted death
        - any medical complications during or after administration of the drugs

c. personal details about all individuals who made a first request, whose requests were approved, who withdrew their request, who died from an assisted death, including:
   - age
   - gender
   - physical condition expected to cause their death
   - use of palliative or end-of-life care
   - main language and any additional languages used
   - use of communication support and advocacy support
   - a protected characteristic under the Discrimination (Jersey) Law 2013.

268. The Minister must consult the Medical Officer of Health to determine what information in the report should be published. As set out in P.18/2024, the combination of a small population size - coupled with the fact that the names of people who have had an assisted death will be recorded in the public register of deaths - is likely to require some details not being published to protect anonymity and privacy.

269. In addition to the annual reporting requirements, the Committee:
   a. may report to the Minister any assisted dying matters it deems relevant
   b. must report to the Minister on any assisted dying matters that the Minister requests.

270. Note: P.18/2024 did not reference reporting requirements related to protected characteristics under the Discrimination (Jersey) Law 2013, but this has been included in response to feedback from the Assisted Dying Scrutiny Panel.

Independent inspection and regulation

271. As described in P.18/2024, appropriate structures and systems are required to ensure the safety, quality and effective delivery of the service, and to provide public assurance of these matters. These include:

   a. the Assisted Dying Assurance and Delivery Committee (as described above)
   b. Review Panel which must undertake a post-death review of every assisted death, in addition to reviewing assisted dying processes that do not end in an assisted death, when required by the Committee to do so
   c. independent oversight by the Jersey Care Commission ("JCC").

272. The draft law, as described in paragraph 323, amends the Regulation of Care (Jersey) Law 2014 and Regulation of Care (Standards and Requirements) (Jersey) Regulations 2018 to allow for the registration and regulation of the Service by the JCC.

273. In the event JCC finds that the Service is failing to meet any of the requirements set out in this law, or under the 2018 Regulations, the JCC will be able to take action in accordance with the JCC's existing escalation and enforcement policy which, in the first instance, is likely result in the JCC issuing the Service with an improvement notice. If the Service contravenes a JCC requirement or fails to comply with an

improvement notice, the JCC may refer information to the Attorney General, for the Attorney General to decide whether to prosecute.

274. The ultimate sanction against services regulated by the JCC is the cancellation of a service provider's registration with the JCC – the effect of which is to shut the service down. However, this 'shut down' power does not apply to essential services provided by the Minister (i.e. a service for which a Minister is the sole provider). As the Assisted Dying Service would meet the definition of an essential service, the JCC could not cancel its registration, and could not shut it down.

275. Hence, in accordance with P.18/2024, the 2014 Law is further amended to provide that the Assisted Dying Service is not an essential service, and in the case of serious failings, its registration may be cancelled by the JCC, effectively shutting it down. However, these amendments provide that, if Service's registration is cancelled, an individual whose assisted death has been approved at Step 5 – but whose assisted death has not yet been carried out – may still have an assisted death providing the cancellation of registration by the JCC does not relate to one of the assessing doctors involved in that individual's assisted dying process.

Assisted Dying Service ("the Service")

Minister to establish the service (Article 77)

276. In accordance with P.18/2024, it is the responsibility of the Minister to establish and maintain the Service, regardless of their views on assisted dying, or the views of others (i.e., a Minister who is opposed to assisting dying on the grounds of conscience cannot shut the Service down). However, there may be circumstances which prevent the Minister from establishing or maintaining the Service, for example, if the numbers of professionals willing to work in the Service is not sufficient to deliver a safe service.

277. The draft law provides that, if the Minister cannot establish and maintain the Service, they must present a report to the Assembly stating why the Service cannot be established or maintained; what they have done and intend to do to resolve the issue and what, if anything, the Assembly may decide to do to help the Minister establish and maintain the Service.

278. **Accountability**

For the purposes of clarity, the draft law sets out that the Service is provided by HCJ, acting for the Minister – i.e., the Minister is accountable for the Service.

The Committee is not an independent entity and it not accountable for the Service, but the Committee has functions and obligations that work to ensure the quality and safety of the Service for which the Minister is accountable.

For the purposes of clarity, if the Service provider is changed, the Minister nevertheless remains accountable for ensuring that the new provider delivers the service, which the

Minister will achieve through the contractual arrangement with the new service provider (i.e., the draft law provides that a Minister, who is opposed to assisted dying, cannot arrange for third party to provide the Service and then accept non-provision by that third party).

Service provider / change of provider (Article 77)

279. The draft law provides that the Assisted Dying Service should be provide by Health and Care Jersey. This accords with most other jurisdictions where assisted dying services are also delivered as part of the public health system - Switzerland and Germany being the exceptions.

280. However, the draft law also provides that the Service may, if required by Regulations, be provided by another entity. This regulation making power (provided for in Article 96) accords with P.18/2024 and works to ensure that the Minister is not precluded from making arrangements for a different entity to provide the Service if, at some point in the future, the Assembly were satisfied that another entity was better placed to manage and deliver the Service.

281. Article 96 also provides regulation-making powers to facilitate any future change of providers. This includes powers to:
    a. transfer employees, equipment, facilities, individuals' records, and responsibility for individuals to a new provider, and
    b. amend various provisions of draft law as necessitated by the change of provider (for example, amendments to the governance and oversight arrangements) except that this cannot affect whether an individual is eligible for an assisted death (i.e., the eligibility criteria cannot be amended as set out in paragraphs 34 - 42)

Exclusive functions (Article 78)

282. The draft law provides that the Service must arrange the services of assisted dying practitioners and associated support services (including counselling, communications support, and advocacy support).

283. This function is exclusive to the Service. No other person may provide, or purport to provide, assisted dying (i.e., a business may not suggest that it provides assisted dying). Furthermore, as set out above it is an offence to advertise or promote assisted dying or the Service with the intention of persuading or encouraging anyone to have an assisted death - although this should not prevent people from giving information about assisted dying for a legitimate purpose.

Fees (Article 78)

284. The draft law provides the Service must not charge a fee for any part of the Service. This accords with P.18/2024. However, Article 94 of the draft law provides that in future, the Assembly may, by Regulation, require the payment of fees (which was proposed via P.18/2024) as a result of third-party service provision, wider fee reform across HCJ, or other system changes that may impact the Service. The regulation-making power is

provided to enable the levying of fees, in the event the Assembly was satisfied that charging for the Assisted Dying Service is consistent with any future approach to health service fees and charges i.e. in the event that service user charges are introduced, as standard, for Government delivered health and care services.

Registration of assisted dying practitioners and certifying doctors, renewal and information on the register (Articles 80, 81 and 83)

285. As set out above, the Committee must arrange for the development and maintenance for the register of assisted dying practitioners and certifying doctors, and the Service must register those professionals.

286. Registration provides critical safeguards:
   a. no person may act as an assisted dying practitioner or certifying doctor unless they are registered. If they do, they will be committing an offence
   b. no professional can be forced to register; it is their choice alone. The draft law provides a right to refuse to apply to be registered and protects professionals who do not register (or who register) from any action by their employer
   c. a professional cannot be registered unless they have undertaken the necessary training and have the necessary competencies
   d. a professional must be professionally registered to be eligible to register with the Service (for example, a nurse with the NCM and JCC; a doctor with the GMC and JCC, etc) ensuring they have met the required standards of education, competency, and conduct to practice their profession
   e. a professional can be deregistered (and therefore unable to practice assisted dying) in response to concerns about their assisted dying practice or their professional practice more generally.

287. People may apply to be registered as a Certifying Doctor, or one or more of the following types of assisted dying practitioner:
   - a Coordinating Doctor
   - an assessing doctor who is not a Coordinating Doctor (for example, a person may register only as an Independent Assessment Doctor or as a Second Opinion Doctor)
   - an Administering Practitioner
   - a Pharmacy Professional
   - an extended team member.

288. Having received an application, the Service must register a person if satisfied that:
   a. it has the necessary information
   b. the person has the required competencies (see paragraph 260h) - i.e., they have the skills, knowledge, character, and health to practice
   c. the person has completed the mandatory assisted dying training for the role (see paragraph 260i)
   d. the person has disclosed any conflicts of interests
   e. the person has a responsible officer if required – i.e., a doctor requires a responsible officer for the purposes of GMC revalidation. The doctor must have a responsible officer at the point of registration, they cannot be 'between' responsible officers.

289. A registered assisted dying practitioner must renew their registration on an annual basis (this does not include a certifying doctor). The draft law provides that they must apply to renew within 3 months of the annual renewal date, i.e. there is a grace period during which a professional can continue to be registered as an assisted dying practitioner before they are removed from the register. This allows for accidental failure to renew in a timely fashion.

290. The Service may renew the registration if satisfied of the matters set out above. If the assisted dying practitioner has not renewed their registration, their registration ends after 18 months, and they are no longer an assisted dying practitioner.

291. The draft law sets out the information that the Service will record on the register. This includes:
    a. the registrant's name and roles; their professional registration bodies names and numbers (for example, their JCC and NMC registration numbers)
    b. whether they have a contract of employment or service with the Service
    c. any disclosed interests
    d. date of initial registration and renewal dates / dates of completion of initial and continuation training
    e. date on which their registration ended and the reason (if applicable).

292. As set out in paragraph 260c, the register is not a public to protect the privacy of practitioners in a small jurisdiction. The draft law prohibits the Service from sharing information on the register unless to the Committee or others for purposes related to governance and investigations (Article 87).

Registration changes, suspension and cancellation (Article 84 to 86)

293. The draft law provides that a registered professional must tell the Service if their professional registration is suspended (for example, suspended by the JCC or NMC); cancelled (whether by them or by the registration body); has conditions imposed (for example, they must be supervised by another professional when undertaking specific tasks) or anything else happens which may affect the registration (for example, their registration body is going to investigate their practice)

294. The Service must suspend a professional's assisted dying registration if their professional registration is suspended and cancel their assisted dying registration if they are no longer professionally registered. Furthermore, the Service may suspend or cancel a professional's assisted dying registration in response to an investigation into their practice (in accordance with Regulations made under Article 96).

Development and publication of document and training (Article 88)

295. The Service must develop documents, information, guidance, and training in accordance with requirements established by the Committee.

Review Panel (Articles 90 to 95)

296. The draft law provides that the Minister must establish and maintain an Assisted Dying Review Panel (the "Panel") and appoint its members.

297. The primary purpose of the Panel is to undertake post-death review to determine whether, in each case, there was proper adherence to the legislation and guidance, and to identify any process matters that may require improvement / change. Post-death review also supports immediate identification of suspected malpractice and, as such, are critical to safeguarding people.

298. The number of members, the appointment process, and members' required knowledge and expertise will be prescribed by Order.

299. As described in P.18/2024, members are likely to include experts from a range of disciplines including legal; end-of-life care specialists; medical ethicists; social care practitioners; medical practitioners with expertise in the types of physical medical conditions that give rise to assisted dying requests; people with expertise in clinical service governance and safety. The draft law provides that there may be remuneration.

300. The Minister may only appoint members in accordance with the Order and as recommended by the Committee. This may include employees of HCJ, but the Committee must be satisfied that the interests of any person recommended for appointment do not conflict with the interests of individuals in the assisted dying process.

301. The Panel must follow the procedures set out in the terms of reference developed by the Committee, and deliver the functions and obligations set out in the draft law. These functions and obligations include:

    a. reviewing every assisted death that is carried out - in reviewing an assisted death, the Panel must review all parts of the individual's assisted dying patient record. They may also request that additional information is provided to them. As set out in P.18/2024 this may include asking assisted dying practitioners, or others, to attend a review panel meeting. Having undertaken the post-death review, the Panel must then decide if the assisted dying process being reviewed accorded with the law and the operational guidance approved under the law. The Panel must report its decisions and findings to the Committee

    b. analysing assisted death reviews – the Panel must, having undertaken 2 or more post-death reviews, consider whether it should recommend to the Committee potential changes or improvements to the assisted dying process, or the requirement for investigation into a professional's practice or performance. The Panel must provide reasons for its recommendations.

302. In addition to the above, if the Committee requests that the Panel undertake a review of an assisted dying process that ended before an individual's assisted death (for example, the individual withdraw their request; the request was not approved; the person died of natural causes) the Panel must undertake that review.

303. All reviews must be undertaken in the timeframes prescribed by Order.

Section 5: Part 4 of draft Law - secondary legislation, forms and final matters

304. Part 4 of the draft law provides for Regulations, Orders, forms, commencement, and other related matters.

Regulations (Article 96) and Orders (Article 97)

305. Article 96 sets out the Regulation-making powers associated with the draft law. This includes powers to amend some provisions of the draft to ensure its continued and ongoing currency (for example, powers to amend some offences; restrictions on disclosure of information; functions of the Committee; functions of the Review Panel; matters related to the assisted dying process which the Review Panel determines should be improved).

306. The draft law provides extensive detail about how a function is undertaken, as opposed to simply providing that a function must be undertaken and, given that the Assisted Dying Service is entirely new, it must be recognised that this detail may require amendment once tested through practical application – providing all essential safeguards are maintained.

307. Article 96 also provides for Regulations to change the provider to the Service.

308. However, in accordance with P.18/2024, the draft law does not allow the assisted dying eligibility criteria to amended by Regulation. Any future change to the eligibility criteria must be via a primary law change which would require Privy Council consideration and Royal Assent. This safeguard is intended to ensure that Privy Council, as well as the States Assembly, are sighted on any changes and to provide a counter to the 'slippery slope' concerns raised in phase 1 and phase 2 public consultations in 2022 and 2023.

<u>Regulations to be made prior to commencement of the Assisted Dying Service</u>

309. Article 96 of the draft law will come into force 7 days after the law is registered, allowing for the Minister to present the following regulation to the Assembly before the law comes fully in force:
    a. Regulations to provide for safe access zones
    b. Regulations related to the investigation of professionals
    c. Regulations related to civil remedy
    d. Regulations related to independent advocacy.

310. Regulations to provide for safe access zones including specifying:
    - activities that are prohibited in a safe access zone (see Article 38), such as doing anything intentionally or recklessly – (i) to obstruct someone's involvement in the assisted dying process; or (ii) to harass someone for their involvement in, or contact with someone involved in, the assisted dying process
    - the periods during which those activities may be prohibited

- the places that are safe access zones, whether being defined as places at which: the assisted dying process is carried out; the Service operates; assisted dying practitioners are employed; by boundaries around a place (for example, the area within 100 metres of the boundary of any private property at which an individual's assisted death is to be carried out)

311. Regulations that provide for the investigation of professionals:

a. Article 71 of the draft law provides that the Committee may investigate the practice of an assisted dying practitioner or a certifying doctor, or the performance of a care navigator, so far as it relates to assisted dying and further to that investigation, may suspend or cancel their assisted dying registration. Suspension or cancellation of assisted dying registration will prevent the person from practicing assisted dying.

b. The investigation must be done in accordance with Regulations made under the draft law.

c. The draft law does not provide the Committee powers to investigate the practice of those professionals more widely (i.e. they may investigate an assessing doctor when they are acting as an assessing doctor, but they may not investigate an assessing doctor when that assessing doctor is acting as a GP). Powers of investigation into wider professional practice are matters for the employer and / or the professional registration body (e.g.: the GMC)

d. Developing the regulations requires extensive consultation with the Jersey Care Commission and UK professional regulatory bodies but, subject to that consultation, it is envisaged that the Regulations will provide for matters including:
   - protocols for notifying professional regulatory bodies and information sharing
   - powers of investigation
   - reports following an investigation
   - removal from the assisted dying register or refusal to renew assisted dying registration following an investigation and associated appeals.

312. Regulations that provide for civil remedy in relation to an employee or partner who suffers detriment because of their decision to participate, or to refuse to participate, in assisted dying (in accordance with Article 38). These Regulations may provide for matters such as:
   a. conferring jurisdiction on a court or tribunal to consider the matter
   b. making of awards of compensation and the recovery thereof
   c. setting of maximum amounts
   d. appeals, offences, exemptions, etc.

313. Regulations to provide for independent advocacy:

a. As set out in paragraph 158, the Minister has determined the Assembly should, by Regulation, make provisions in relation to independent advocates who support

people who have requested an assisted death. This will align with the draft UK Bill and will mirror similar independent advocates provisions in other Jersey laws.

b. Subject to consultation, it is envisaged that the independent advocacy regulations may make provisions as to –
- the training and/or qualifications required to be appointed as an independent advocate
- the procedure for appointment of independent advocates
- provision for payments
- criteria for a 'qualifying person' who may be supported by an independent advocate and the steps to be taken to ensure that a "qualifying person" who has requested assisted dying is aware of the availability of the services of independent advocates
- matters in which independent advocates may help a qualifying person, in relation to an assisted dying request or the assisted dying process and the functions they may undertake when giving such help.

Orders (Article 97)

314. Article 97 provides for matters that the Minister may specify by Order, including where a meeting under this law may be held and whether it may be held electronically (as per paragraphs 139 – 146. This may be subject to change in the future, depending on changes to UK provisions related to assisted dying and offences related to suicide)

315. A number of these Orders must be made prior to commencement of the Assisted Dying Service, including those relating to the membership of the Committee and Review Panel, and the information that must be contained in all the forms to be completed under the draft law.

Commencement / transitional provisions (Articles 100 and 102 / Schedule 2)

316. As set out in Article 102, key Articles will come into force 7 days after the draft law comes into force. These Articles enable the Service to be established (for example, the Committee may be stood up, the competencies, training and operation guidance may be developed, and assisted dying practitioners may be registered) but not provide for the Service to commence delivery. For the avoidance of doubt, Schedule 2 clearly states that assisted dying cannot be provided until the entirety of the law comes into force.

317. It is anticipated the rest of the law will come into force around 18-months post adoption of the law (c. late summer 2027).

Amendments to other legislation (Article 101 / Schedule 3)

318. The Cremation (Jersey) Regulations 1961 currently prohibits a cremation where it appears that the death has, or might have, resulted from poison. The Regulations are amended to disapply this prohibition in the case of an assisted death.

319. The Regulations are further amended to clarify the existing requirements regarding who may not be a confirming practitioner. The amended Regulations also provide additional requirements where the death is an assisted death, so that an attending practitioner cannot be related to, or a partner of, an Administering Practitioner or the individual's certifying doctor.

320. In accordance with P.18/2024, the Homicide (Jersey) Law 1986 is amended to explicitly clarify that suicide is not an offence in Jersey and to create a new offence of encouraging or assisting suicide, in line with Section 2 of the UK Suicide Act 1961. Encouraging or assisting suicide would include, for example, buying lethal drugs for a person with the intention that they will take them to end their life. This is an area of potential increased risk given the availability of some lethal drugs on-line and the associated prosecutions relating to supply of lethal drugs in jurisdictions such as Canada.

321. The Inquests and Post-Mortem Examinations (Jersey) law 1995 provides that a person who believes that another person, who is under the care of medical practitioner, has died from causes other than natural causes, will notify the police, who will then notify the Viscount. This is amended to provide that notification to the Viscount is not required in the case of an assisted death, although the amendment does not prevent action by the Viscount where there are concerns about the manner of the assisted death.

322. The Marriage and Civil status (Jersey) Law 2001 is similarly amended to provide that there is no duty on the relevant registrar to notify the Viscount about an assisted death.

323. The Regulation of Care (Jersey) Law 2014 and Regulation of Care (Standards and Requirements) (Jersey) Regulations 2018 are amended to provide for the registration and regulation of an Assisted Dying Service by the JCC. The amendments to the 2014 Law and 2018 Regulations, which accord with P.18/2024 (see paragraphs 271 - 275) collectively work to provide that:

    a. the Assisted Dying Service is a defined regulated activity

    b. the Service is required to discharge its statutory functions in accordance with the assisted dying law, enabling the JCC to regulate the Service fully, ensuring that it is compliant with all its statutory responsibilities under the assisted dying law, as well as the general requirements placed on all services under the Regulation of Care Law

    c. the Assisted Dying Service is not an essential service, enabling the JCC to cancel its registration in the event of serious service failings, thereby effectively shutting the Service down. Except that, an individual whose assisted death has already been approved may proceed to have an assisted death, providing the reasons for cancellation of registration do not relate to one of the assessing doctors involved in that individual's assisted dying process.

Section 6: Resources and financial implications

324. The 2026 Government Budget includes monies associated with the establishment and ongoing delivery of the Assisted Dying Service. This accords with P.18/2024, which clearly stated that resources currently allocated for palliative care or other health and care services in Jersey would not be used to funded assisted dying, and that new monies were required.

325. The anticipated costs associated with the implementation and ongoing provision of the Assisted Dying Service are set out below. Note: these costs have been updated since the publication of P.18/2024.

326. Whilst considerable care has been taken in developing the estimated costs, it must be recognised that there is an inevitable degree of uncertainty as to their accuracy.

327. *Implementation costs* include, for example: developing a bespoke training package for assisted dying practitioners. Given that there is no existing equivalent training package in the UK, the development costs can only be based on those associated with training packages for existing health care services.

328. Ongoing *delivery costs* which will fluctuate on an annual basis dependent on factors such as:
- numbers of requests for assisted dying in Jersey, and associated complexity of assessments
- uptake and requirement for counselling, wellbeing and bereavement support
- uptake and requirement for interpreting, communication support, and advocacy
- regulatory action and appeal.

Estimated number of assisted deaths per year

329. The costs set about below are based on an estimated 28 people having a first assessment in 2029, with 24 of those people going on to have a second assessment, and 14 of those people going on to have an assisted death. With fewer assisted deaths during the first two years, as has been the case in other jurisdictions where assisted dying has been implemented:

	2027 (6 months of Service)	**2028**	**2029**
First Assessments	9	17	28
Second Assessments	7	9	24
Assisted Deaths	4	8	14

330. The number of assisted deaths - as a % of all deaths - in jurisdictions where assisted dying is permitted ranges from 0.86% (in Oregon) to 4.7% in Canada. This variation is based on multiple factors, including the differences in eligibility criteria and assessment process.

331. The jurisdiction that is most similar to Jersey, in terms of eligibility criteria and assessment is Western Australia, hence the estimated number of assisted deaths in Jersey is based on figures provided in the Western Australian Voluntary Assisted Dying Board 2024 annual

report.[23] However, these figures should be taken with a degree of caution given the variations in geography, societal make-up and health service delivery between the two jurisdictions.

Estimated staffing hours per assisted death

332. As set out below, based on discussion with Jersey based health and care providers, it is assumed than each assisted death will require an average of 85.5 hours of staff time, although this is likely to vary significantly dependent on the circumstances of the individual. 85.5 hours is more than the estimated 60 hours per assisted death reported in some Australian jurisdictions - and more than the 32 hours set out in the UK impact assessment - but, in developing the assisted dying costs – given the known, unknowns - officers have erred on higher end of estimates.

Estimate staffing hours per assisted death	
	hours
Assessment	
Coordinating Doctor	19
Independent Assessment Doctor	8
Extended team members	26
Additional assessments for relevant opinions (e.g. mental health assessment)	6
Delivery	
Pharmacist professionals	7
Administering Practitioner (& supporting AD Service team member)	15.5
Certifying Doctor	4
Total	**85.5**

UK impact assessment

333. The impact assessment published as part of the recent UK parliamentary debate on Terminally Ill Adults (End of Life) Bill set out both the potential costs and the potential cost savings associated with assisted dying.[24] The estimated UK costs differ considerably to those set out in the report, due to two key factors:

a. *UK estimates on number of assisted deaths* - in calculating the estimated number of assisted deaths, the UK impact assessment is based on the Oregon death rate (0.86% of all deaths in 2023), whereas - as noted above – the Jersey's estimate is based on Western Australia assisted death rate figure (1.67% of all deaths in 2023). This is because the

[23] Voluntary Assisted Dying Board Western Australia Annual Report 2023–24
[24] Terminally Ill Adults (End of Life) Bill: impact assessment - GOV.UK

draft UK bill only permits assisted dying for people with 6 months life expectancy (as per Oregon), where the Jersey draft law permits assisted dying for people with 6 months life expectancy or 12 months where the person has a neurodegenerative condition (as per Western Australia)

b. *Differences in the proposed assessment process etc* - the UK proposals do not provide for the functions - or costs – associated with the role of the Care Navigator, the Committee, or the Review Panel (all of which have been factored in the Jersey proposals). Further to this, the UK proposals do not take account of costs such as the provision of wellbeing and bereavement support.

Costs

334. Total estimated one-off and recurring costs associated with the establishment and on-going delivery of the Service (as per Government Budget 2026-2029)

	2026	**2027**	**2028**	**2029**	**Total**
	£	**£**	**£**	**£**	**£**
One-Off Costs	524,826	262,313	29,000		816,139
Recurring costs		464,145	658,800	718,000	1,840,945
Investment Total	**524,826**	**726,458**	**687,800**	**718,000**	**2,657,084**

335. Total estimate costs by category:

	2026	**2027**	**2028**	**2029**	**Total**
Category	**£**	**£**	**£**	**£**	**£**
Implementation	201,022	73,453			274,475
Training (development and delivery)	230,000	153,631	76,550	30,778	459,619
Information management	5,000	10,000	15,000	10,000	40,000
Public information		8,860			8,860
Recruitment	30,000	130,000			160,000
Staffing costs (administrative and clinical)		169,408	298,240	399,342	898,330
Facilities/ equipment/ supplies		45,770	31,540	35,410	112,720
Wellbeing & support services		38,988	77,976	77,976	194,940
Assurance & Delivery committee		32,430	89,659	65,659	187,748
Regulation & oversight	58,804	63,918	98,835	98,835	320,392
TOTAL	**524,826**	**726,458**	**687,800**	**718,000**	**2,657,084**

336. Implementation costs include, for example, provision of a programme manager to oversee the establishment of the new service and associated workstreams, such as the development of operational guidance and the assisted dying person record.

337. Training costs include developing the training package for assisted dying practitioners and certifying doctors; developing the general assisted dying training module for on-island health and care professionals; and recurring costs associated with the delivery of the training, including the cost of staffing time when completing the training.

338. Information management costs include the development and ongoing maintenance of an assisted dying practitioner register and the assisted dying person record.

339. Public information costs include one-off costs associated with the development of a dedicated webpage for the Service on gov.je and the production of leaflets to inform the public of the contact details for the Assisted Dying Service (where a health care professional chooses not to refer them to the Service).

340. Recruitment costs include one-off costs associated with recruiting Assisted Dying Service staff, the independent chair and external Committee members, and members of the Review Panel.

341. Staffing costs include recurring costs for Assisted Dying Service practitioners, Care Navigators, and administrative staff.

342. Facilities/ equipment/ supplies costs include costs associated with the administration of the service – such as IT and office equipment, and recurring costs related to the provision of assisted dying, including the approved drugs.

343. Wellbeing & support services costs include recurring costs for support for Assisted Dying Service staff (such as access to counselling) and wellbeing support for individuals requesting assisted dying and their families (including bereavement support), plus costs of interpretation and independent advocacy for individuals requesting assisted dying.

344. Assurance & Delivery committee costs include recurring expenditure such as the remuneration of the independent committee members, administrative costs and costs associated with the production of an annual report on assisted dying in Jersey.

345. Regulation & oversight costs include both one-off and recurring costs associated with inspection and regulation of the Service by the Jersey Care Commission; and costs associated with the Review Panel.

346. Note: these costs do not include insurance costs, for example, any additional medical indemnity insurance protection, if required. Such cost projections cannot be determined prior to the adoption of the law.

Children's Rights Impact Assessment

A Children's Rights Impact Assessment (CRIA) has been prepared in relation to this proposition and is available to read on the States Assembly website.

Human Rights Notes

The notes on the human rights aspects of the draft Law in **Appendix 6** have been prepared by the Law Officers' Department and are included for the information of States Members. They are not, and should not be taken as, legal advice.

APPENDIX 1 TO REPORT

Background to P.18/2024: Previous debates, consultation and engagement

1. The proposals outlined in P.18/2024 were developed following several phases of consultation with the public and with professional stakeholder organisations.

Citizens' Jury and States Assembly 'in-principle' debate

2. In November 2021, the States Assembly ("the Assembly") agreed, in principle, that assisted dying should be permitted in Jersey (P95/2021)[25] but that, prior to the preparation of the law drafting instructions, detailed proposals should be brought back to the Assembly for debate.

3. P.95/2021 was informed by the key recommendations of the Jersey Citizens' Jury on Assisted Dying which took place between March and May 2021, with the final Citizen's Jury report being published on 16 September 2021.[26]

4. The Jersey Citizens' Jury on Assisted Dying was commissioned by the previous Minister for Health and Community Services, Deputy Richard Renouf, following community interest in the introduction of assisted dying in 2018.[27]

5. A citizens' jury is a form of deliberative democracy, where a small group of people, representative of wider demographics of a given area, come together to carefully consider a complex issue. The Jersey Citizens' Jury on Assisted Dying consisted of 23 Jersey residents who were broadly representative of the Island's population in terms of age, gender, location, socio-economic status, place of birth and attitude towards assisted dying. The jury members came together over 10 online sessions to examine evidence, hear from expert witnesses and consider the central question "Should assisted dying be permitted in Jersey and if so, under what circumstances?".

6. At the end of the jury process, 78% of jury members agreed that assisted dying should be permitted in Jersey.[28]

Note: Citizen's deliberation processes

The use of citizen's deliberation processes, such as a jury, was relatively new to Jersey and, as such, some Assembly members raised questions about the process during the P.95/2021 debate. The Public Accounts Committee subsequently reviewed the use and effectiveness of

[25] https://statesassembly.je/publications/propositions/2021/p-95-2021
[26] Final Report from Jersey Assisted Dying Citizens' Jury (gov.je)
[27] Citizens' Jury on assisted dying in Jersey (gov.je)
[28] Detailed reports relating to the establishment of the Jury and the Jury's final recommendations can be found at www.gov.je/assisteddying

such processes and concluded that the Jersey Citizens' Jury on Assisted Dying should be utilised as the model of best practice when establishing future deliberative bodies. [29]

Following Jersey's Citizen's Jury on assisted dying, a Citizen's Assembly on end-of-life matters, including assisted dying was held in France in 2022/23[30] and a Citizen's Jury on assisted dying took place in England in 2024. [31]

7. During the P.95/2021 debate, the Assembly noted the need for further consultation with both the public and professional stakeholders, in order to inform the development of the detailed proposals outlined in P.18/2024. That was undertaken in two phases.

Phase 1 & 2 consultation

8. During March and April 2022, Islanders were asked to take part in the Phase 1 of public engagement on assisted dying proposals. Following the 'in principle' decision made by the Assembly, Islanders were invited to share their comments, thoughts and questions on assisted dying in Jersey. Feedback from the public was collected online via email, social media and sli.do, and in-person at a series of engagement events at various parish halls and the town library. Views were collected and published as key themes and questions in the Phase 1 public engagement summary report.[32]

9. Phase 2 of the public consultation focused on detailed proposals for assisted dying in Jersey and took place over a 12-week period between October 2022 and January 2023.[33] Approximately 1,300 people and organisations responded to this second phase of consultation. The consultation feedback report was published on 28 April 2023.[34]

Ethical review[35]

10. Having considered the phase 1 and phase 2 consultation feedback, which was extensive and demonstrated a wide range of views towards the proposals, the previous Council of Ministers endorsed a recommendation by the former Minister for Health and Social Services to commission an external ethical review of the proposals. This was done with a goal of ensuring that States Members would be sighted on the range of complex ethical and moral considerations associated with these proposals.

11. The ethical review was undertaken by a team of three experts of medical ethics and law, who hold a range of views on assisted dying, as set out in the introduction to that review:

[29] p.a.c.1 2022 - use and operation of citizens' panels, assemblies and juries in jersey.pdf (gov.je)
[30] French citizens' assembly on assisted dying – Participedia
[31] Citizens' Jury – Nuffield Council on Bioethics
[32] Public engagement summary report on assisted dying in Jersey (gov.je)
[33] Assisted dying in Jersey consultation (gov.je)
[34] Assisted Dying in Jersey Phase 2 Consultation Feedback Report (gov.je)
[35] Assisted Dying in Jersey Ethical Review Report (gov.je)

- *Professor Richard Huxtable is in favour of adopting a "middle ground" (or compromise) position on assisted dying, which seeks to accommodate arguments for and against allowing assisted dying;*

- *Professor Trudo Lemmens has become increasingly concerned about how assisted dying regimes develop over time. He is opposed to legalising the practice outside a clearly delineated end-of-life context and is concerned about the overall ability to monitor the practice;*

- *Dr Alexandra Mullock is broadly in favour of assisted dying as a compassionate response within a carefully regulated scheme that safeguards individuals who might be regarded as vulnerable if assisted dying is permitted.*

12. The ethical review summarises ethical arguments on key aspects of assisted dying and maps these ethical considerations across the Jersey-specific proposals.

13. The review authors worked on the basis that assisted dying would be permitted in Jersey (as per the States Assembly P.95/2021 "in principle" decision). As such, the authors did not engage with the general question of whether (or not) it would be appropriate to legalise assisted dying; rather, they focused on the proposals set out in Phase 2 consultation. They were specifically asked to address 16 questions focused on the ethical considerations related to proposed eligibility criteria, assessment, approval and delivery process in Jersey, and associated key safeguards. These questions are detailed Chapter 1 of the Assisted Dying in Jersey Ethical Review report.

Professional Leads working group, UK professional bodies and expertise in other jurisdictions

14. A Government of Jersey Professional Leads working group was established in February 2022 to advise on matters relating to assisted dying service development and delivery.[36] That group included the Medical Director; Chief Nurse; Chief Pharmacist; Chief Allied Health Professional; Director of Mental Health & Adult Social Care; Associate Medical Director for Prevention, Primary and Intermediate Care; Accident and Emergency Consultant – GMC lead contact, plus the Chief Inspector of the Jersey Care Commission as an observer. It is supported by policy representatives from SPPP (Strategic Policy, Planning and Performance).

15. The Phase 2 consultation and a draft of P.18/2024 were reviewed by the Jersey Care Commission, who confirmed that they agree with the proposed arrangements for the regulation and inspection of the Jersey Assisted Dying Service.

16. Engagement with the UK professional regulatory bodies began in August 2021. Individual and collective sessions have taken place with General Medical Council (GMC); Nursing and Midwifery Council (NMC); Health and Care Professions Council

[36] Professional leads working group Terms of Reference can be found at https://www.gov.je/Caring/AssistedDying/Pages/AssistedDying.aspx

(HCPC); and General Pharmaceutical Council (GPhC). Topics for consideration included: conscientious objection; how the introduction of legislation may impact on professional registration requirements; guidance and training for professionals and oversight of registered professionals. The GMC and NMC provided formal feedback to the Phase 2 consultation and a draft of the P.18/2024 report and proposition. HCPC were provided with copies of the Phase 2 consultation and a draft of the P.18/2024 report and proposition and provided feedback to the draft report and proposition. The GPhC was provided with copies of the Phase 2 consultation and a draft of the P.18/2024 report and proposition but did not provide formal feedback.

17. Discussion of the proposals has taken place with the British Medical Association (BMA), who provided formal comment in a letter to the Minister in February 2024. In addition, preliminary conversations with the Academy of Medical Royal Colleges and the Royal College of Nursing have been held.

18. The policy proposals set out in P.18/2024 are based on extensive research of assisted dying legislation and practice in jurisdictions where assisted dying is permitted. This is in addition to in-person / online discussions with professionals in other jurisdictions who have direct expertise and practical experience of assisted dying, including:

- The Netherlands:
  - Former Chairman of the Dutch Euthanasia Review Committee
  - Bioethics specialist and former committee member of the Dutch Euthanasia Review Committee

- Canada:
  - Palliative care consultant and assisted dying practitioner, former President, Canadian Medical Association
  - Specialist palliative care physician, who does not practise assisted dying

- Australia:
  - Consultant anaesthetist and assisted dying practitioner
  - Palliative Care Physician and assisted dying practitioner
  - Chair, Voluntary Assisted Dying Implementation Taskforce, South Australia*

- New Zealand:
  - Assisted Dying Registrar for New Zealand*

* during EPSO [European Partnership for Supervisory Organizations] Assisted Dying/ End of Life supervision working group

APPENDIX 2 TO REPORT

Summary of responses to health and care professionals' participation in assisted dying survey

1. A survey was undertaken in early 2025 to better understand the views of on-island health and care professionals in terms of their intent to participate in assisted dying, should the Assembly adopt the draft assisted dying law.

2. The survey questions and methodology for dissemination was developed with input from assisted dying health and care professionals working group. The survey ran for period of 6 weeks between 10 February and 24 March 2025.

3. A link to the online survey was provided to:
   - All Health Care Jersey (HCJ) staff via internal communication channels
   - Key non-HCJ employers and distributed to all staff – including Family Nursing and Home Care (FNHC) & Jersey Hospice
   - All registered care home & home care managers via Jersey Care Commission (& to members via Jersey Care Federation)
   - All GP practices via the Primary Care Governance team & to the Primary Care Board
   - Non-HCJ pharmacists via superintendent pharmacists.

4. In considering the responses, the limitations and extent of a survey of this nature should be taken into account – the survey provides a snapshot of the views expressed by the health and care professionals that chose to respond at that time. It does not seek to represent the wider views of all on-island health and care professionals.

5. The survey responses indicate that a number of professionals are of the view that they would be prepared to participate in assisted dying and practise as an assisted dying practitioner.

6. In total 378 complete responses were received:

Occupation	No. responding
Doctor	64 (47% consultant, 36% GP, 17% other)
Registered nurse	119
Social Worker	15
Allied Health Professional (AHP)	42
Care assistant	87
Porter/housekeeper	0
Other	11

7. Summary of respondent details, by profession:

	Doctors	Nurses	Pharmacists	AHPs	Social Workers
Respondent details					
% who are Jersey resident	97%	100%	90%	100%	100%
% who are an HCJ employee	61%	53%	65%	88%	93%
% planning to leave workforce in >5 years	14%	18%	8%	7%	7%

8. Summary of views towards assisted dying, all respondents:

View towards assisted dying	% of respondents
Supportive	59%
Neutral	14%
Opposed	15%
Undecided/prefer not to say	12%

9. Summary of willingness to participate in general tasks associated with assisted dying (i.e. not specifically working for the assisted dying service), by profession:

	Doctors	Nurses	Pharmacists	AHPs	Social Workers
General participation					
Would you be prepared to provide a patient with information on assisted dying, if requested?	75% - yes	76% - yes	83% - yes	71% - yes	93% - yes
Would you be prepared to refer patient to the assisted dying service, if requested?	63% - yes	69% - yes	78% - yes	71% - yes	93% - yes
Would you be prepared to provide a supporting/professional opinion to the assisted dying service, if requested?	47% - yes	55% - yes	58% - yes	55% - yes	80% - yes

10. Number of professionals who stated they would be prepared to undertake an assisted dying practitioner role for the assisted dying service:

Role	No. of respondents stating they would be prepared to participate *[as total number, <u>not</u> as a % of respondents]*
assessing doctor (Coordinating Doctor or Independent Assessment Doctor)	19
Administering Practitioner	51 (35 nurses + 16 doctors)
Extended (MDT) member	92 (58 – nurses, 11 – social workers, 23 -allied health professionals)
Pharmacy Professional	22

APPENDIX 3 TO REPORT

Assisted dying safeguards case studies – individuals and professionals

1. The case studies below illustrate how safeguards will apply in different circumstances:

Individuals requesting assisted dying

- Person 1: vulnerable elderly, possible coercion
- Person 2: right to privacy, complications with administration of substance
- Person 3: learning disability, dementia, capacity concerns
- Person 4: end stage of life, impact on pace/progression of process, waiver of requirement for future capacity
- Person 5: possible coercion, history of domestic abuse, impact of mental health on capacity
- Person 6: mental health diagnosis and capacity
- Person 7: possible coercion due to inheritance considerations
- Person 8: vulnerable elderly, no immediate family, 'tired of life' request
- Person 9: mental health diagnosis (anorexia) and capacity, second opinion request

Health and care professionals

- Professional 1: opposed to assisted dying for reasons of faith
- Professional 2: opposed to assisted dying for reasons of personal circumstances
- Professional 3: assisted dying practitioner changing roles

2. These case studies are hypothetical and have been developed to demonstrate how safeguards will operate. Any similarity to actual events or persons is coincidental.

3. There are standard parts of the process, which apply in all cases, which are not set out in detail in all the case studies (for example, the second request is always signed by a witness). This is to avoid repetition.

Person 1

- Jean aged 72, widowed, 3 adult children (2 UK based, 1 in Jersey)
- Lives in annexe of eldest daughter's family home in Jersey
- Diagnosed with terminal lung cancer 2 months ago, after 3 unsuccessful rounds of chemo/radiotherapy
- In receipt of domiciliary palliative care

Possible safeguarding considerations

- Coercion from family to seek assisted death to ease care burden

- Jean is worried about being a 'burden' on her daughter, who has a young family and is already caring for Jean

Circumstances / sequence of events

- Jean seeks appointment with her long-term GP to discuss assisted dying. Jean's GP is a registered assisted dying practitioner in Jersey. Jean's daughter is in attendance. GP refers Jean to the Jersey Assisted Dying Service. He tells Jean he is willing to be her Coordinating Doctor should she wish to proceed with a first request.

- On receiving the referral, the Care Navigator contacts Jean, who confirms she wishes to make an appointment to make a first request.

- Jean makes first request to the Coordinating Doctor (who is her GP). She asks that she is assessed for an assisted death as soon as possible.

- During the first assessment process, which includes multiple meetings with the Coordinating Doctor, Jean discusses her wish for an assisted death and mentions a documentary on the subject she watched with her daughter. She explains that she had not previously considered assisted dying but, in the weeks since seeing the documentary she has given the matter a great deal of thought and is confident in her decision.

- During the first assessment they discuss her treatment and care options, including options for further chemotherapy.

- The Coordinating Doctor confirms with Jean's consultant that her diagnosis is terminal and life expectancy is less than 6 months.

- A social worker (as part of the assisted dying extended team) explores the potential for coercion. The social worker speaks with Jean about family dynamics and then speaks separately with close family members. Jean has given permission for the social worker to speak with other family members.

- The social worker determines that the family is supportive of Jean's decision, but that Jean is making the decision voluntarily and without coercion.

- The Coordinating Doctor assesses Jean as meeting the eligibility criteria.

- The next week Jean decides to pause the process and undergo an additional round of chemotherapy as suggested by her consultant. [As with all individuals requesting assisted dying, all care and treatments should continue regardless of the assisted dying request.]

- After 2 weeks, Jean makes the decision to:

a. stop chemotherapy, given the level of pain and suffering she is experiencing, and on the understanding that the treatment would likely not prolong her life for more than a month, and
b. continue with the assisted dying process by requesting that her second assessment takes place.

- The Independent Assessment Doctor, who has not previously met Jean, reviews the social worker assessments requested by the Coordinating Doctor, then carries out a separate full independent assessment with Jean. The Independent Assessment Doctor also determines that Jean meets the eligibility criteria.

- The Coordinating Doctor meets with Jean who makes a second request for assisted dying, signed by an independent witness.

- Given the progression of her disease, he explains Jean may wish to sign a waiver of requirement for future capacity so that the assisted dying may proceed if Jean loses decision-making capacity after receiving approval for assisted dying but before the assisted death taking place.

- The Coordinating Doctor completes the Administrative Review and approves Jean's request for an assisted death. Jean is informed she may proceed to the planning stage for her assisted death when she chooses to (allowing for a minimum of two working days before the assisted death in the event of any appeal).

- Earlier in the assessment process the Coordinating Doctor had also offered to carry out the role of Administering Practitioner, which Jean chooses to accept.

- Jean requests a care plan meeting with the Administering Practitioner, with her daughter in attendance. Jean decides that she wants:
    - her assisted death, at home, with close adult family members in attendance
    - to sign a waiver of requirement for future capacity

- The Administering Practitioner and an extended team member nurse arrive at Jean's home on the agreed date/time. The Administering Practitioner carries out final review of Jean's capacity, and her request for an assisted death checking that her decision is voluntary.

- The Administering Practitioner determines that Jean still has capacity so there is no requirement for the waiver of requirement for future capacity to be relied on.

- Jean decides she would like her daughter to support her to take the approved drugs even though this was not specified in the Assisted Death Care Plan. Her daughter agrees and the Administering Practitioner explains to the daughter how to support her

mum, and that the administration can only be carried out under his direction - this is all recorded on the Final Consent and Review Form. The nurse acts as a witness to this.

- Jean is supported by her daughter to self-administer the approved drugs orally and loses consciousness a few minutes later, the Administering Practitioner stays nearby, though in a different room at the request of Jean, as recorded in her Care Plan.

- The Administering Practitioner checks on Jean frequently and records her death 23 minutes after ingesting the substance. The Administering Practitioner completes the Post-Assisted Death Administration Form, this includes details of the substance administered, time of administration and time of death, any medical complications or interventions taken.

Summary of key safeguards

- Assessment by 2 independent assessing doctors
  - GP – knows family and has an understanding of the family dynamics
  - balanced by Independent Assessment Doctor who has not previously treated Jean
  - both assessing doctors must complete a declaration of interest form to confirm they are not related to individual making request or set to gain from their death

- Extended team
  - additional social worker assessment considers family dynamic and rules out risk of coercion / request for assisted dying not being voluntary

- Assisted Dying Person Record records all assisted dying information
  - allows for an update to the Assisted Death Care Plan (i.e. daughter supports Jean to self-administer), this change is noted on the Final Consent and Review form.

- Pace and progression driven by the individual
  - Jean decided to pause the process for further chemotherapy but then resumed process after 2 weeks – opportunity to slow or pause process to explore all treatment options.

- Continued care and treatment
  - Jean continues to be able to access treatment (i.e., further chemotherapy) whilst progressing with her assisted dying request

- Waiver of requirement for future capacity
  - in place, though not required in this case

- Administering Practitioner present throughout delivery of assisted death - oversees administration of medication

- daughter able to support Jean to ingest substance but under medical guidance of Administering Practitioner

Person 2

- Robert, 84, married, 2 grown children (both live in UK)
- Lives with wife in private residence
- Diagnosed with end stage COPD (Chronic obstructive pulmonary disease)
- Wife is opposed to assisted dying
- In receipt of domiciliary palliative care

Possible safeguarding considerations

- Robert does not want to inform family member of his request.
- Wife not supportive of Robert's wishes for end of life.

Circumstances / sequence of events

- Robert mentions his wish for assisted dying to his palliative care nurse, who refers him to the Jersey Assisted Dying Service.
- Robert speaks with the Care Navigator and is assigned a Coordinating Doctor.
- During his first appointment with the Coordinator Doctor, Robert makes his first request for an assisted death. He also tells the Coordinating Doctor that his wife is opposed to assisted dying so he does not want her to know about his request. This is noted in his assisted dying record by the Coordinating Doctor who explains to Robert that he has the right to keep his request confidential but not being able to speak with key family members may hinder both the Coordinating Doctor's and the Independent Assessment Doctor's ability to determine if Robert is eligible for assisted dying, on the basis that they may not be able to determine if his wish is voluntary, clear, settled and informed.
- Robert decided he wishes to proceed to the next step and requests a first assessment. During the first assessment process Robert further discusses his wife's views, which are based on her strong religious convictions, and confirms to the Coordinating Doctor that he does not want her to be made aware of his request.
- They also discuss Robert's treatment and care options and the fact that he has a terminal diagnosis with life expectancy of less than 6 months. The Coordinating Doctor determines Robert has decision-making capacity and is of the view that Robert's wish for assisted dying is voluntary, clear, settled and informed but decides to seek further professional opinion to confirm this.

- A social worker carries out an additional assessment with Robert and his daughter, who is visiting the island and who Robert has confided in. Having spoken with Robert and his daughter, the Social Worker confirms they are also of the view that Robert's request is voluntary, clear, settled and informed.

- Coordinating Doctor determines that Robert meets the eligibility criteria set out in law.

- The next week the Independent Assessment Doctor reviews relevant opinions requested by the Coordinating Doctor, then carries out a separate, independent assessment. The Independent Assessment Doctor also determines that Robert meets the eligibility criteria.

- The Coordinating Doctor meets with Robert who makes a second request for assisted dying, signed by an independent witness.

- The Coordinating Doctor completes the Administrative Review, approves Robert's request for assisted dying and informs Robert he may proceed to the planning stage for his assisted death

- Robert and the Administering Practitioner meet to discuss his Care Plan. Robert is accompanied by daughter, who has extended her stay on-island.
    - Robert wants to self-administer the substance

    - The Administering Practitioner talks through the details of self-administration including the potential complications

    - Robert consents to the Administering Practitioner administering additional medication to complete the assisted death in the event of any complications with self-administration

    - They have a detailed discussion about the fact that Robert's wife still does not know about his request. Robert makes the decision to tell his wife with the support of his daughter

- Robert informs his wife, who is shocked. Whilst she acknowledges his extreme suffering, she cannot accept his decision. The Care Navigator contacts Robert's wife and offers her access to a counselling and support service, which she accepts.

- A few days later Robert meets again with the Administering Practitioner to finalise the Assisted Death Care Plan.

- The Administering Practitioner and extended team member nurse attend Robert's home on the agreed date and time. Robert's daughter is also in attendance. The

Administering Practitioner carries out a final review and Robert is assessed as having capacity and making a voluntary request, this is recorded on the Final Consent and Review form.

- As a precaution (and as Robert had consented to it in his Care Plan) he has an IV inserted prior to taking the approved drugs orally.

- Robert is supported to self-administer orally but struggles to swallow the substance. He nevertheless loses consciousness a few minutes later.

- The Administering Practitioner checks on Robert frequently, however he still has a pulse after 60 minutes. In accordance with the guidance produced by the Assurance and Delivery Committee, and with Robert's prior consent, the Administering Practitioner administers an additional dose of the substance intravenously. There are no further complications, and 3 minutes later the Administering Practitioner confirms Robert's death.

- This is recorded in the Final Consent and Review Form, including the approved drugs given, dosage and time to death.

- During the post-death review, the Assisted Dying Review Panel give detailed consideration to: the length of time it took Robert to die; whether the necessary consent was given for IV administration; whether the Administrating Practitioner should or could have taken a different course of action. The review concludes that there were no errors and the care provided to Robert accorded with standards.

Summary of key safeguards

- Right to privacy
    - Robert has a right to privacy – he understood that whilst his wife did not have to be informed of his request, his decision might impact on the assessing doctors' ability to determine eligibility.

- Pace and progression driven by the individual
    - This allowed Robert the time and space necessary to help him decide that he would discuss his wishes with his wife. As a result, the Care Planning process took place over 2 separate meetings a number of days apart.

- In event of medical complications, option to consent to IV administration in Care Plan
    - Administering Practitioner discuss process and risks involved in administration of approved drugs. Robert was clear he wanted to self-administer, but also aware of possible complications and willing to consent to IV administration, if required.

- Support for family members
    - Access to counselling / support services via Assisted Dying Service for Robert's wife

- Assisted Dying Delivery and Assurance Committee - development of guidance and protocols
    - Clear protocol were in place for the Administering Practitioner to follow in the event of medical complications, including delayed death following oral ingestion of the approved drugs.

- Post-death review
    - External review focused on the delivery of the assisted death, and whether the steps taken by the Administering Practitioner were appropriate and in line with the law and guidance.

Person 3

- Sean, 59, single, no children, 1 elderly sister who lives in Jersey
- Lives in supported housing run by Les Amis
- Has a moderate learning disability and has recently been diagnosed with vascular dementia
- Not in receipt of palliative care

Possible safeguarding consideration

- Sean may not have decision-making capacity to request an assisted death, either due to his learning disability or the disease progression of dementia.

Circumstances / sequence of events

- Sean lives in supported accommodation; he is able to express his views and wishes fluently. His learning disability impacts on his social and emotional interaction with others.

- Sean attends a GP appointment regarding his dementia diagnosis. His care worker also attends at Sean's request.

- At the appointment Sean expresses his concerns about the future and the impact dementia could have on him. Sean does not use the term 'assisted dying' but talks to the GP about his cousin in Australia who the doctor helped to die when he got terminal cancer. Sean says he wants the same thing.

- The GP explains the term assisted dying and the associated eligibility criteria. He also explains that, given Sean is likely to live much longer than 6 months, and that he

does not feel Sean is currently experiencing 'unbearable suffering', it is unlikely that Sean will meet the criteria. He nevertheless offers to refer Sean to the Jersey Assisted Dying Service.

- A Care Navigator meets with Sean and his care worker to provide more information about assisted dying. Sean asks to see a Coordinating Doctor so that he can make his first request.

- At a meeting with the Coordinating Doctor, the Coordinating Doctor also explains the eligibility criteria and informs Sean he may not be found eligible. Sean nevertheless wants to proceed.

- A specialist learning disability nurse from the extended team is asked to assess Sean's decision-making capacity. Sean is found to have the capacity to:

    - understand information or advice about an assisted dying decision

    - understand the matters involved in an assisted dying decision

    - understand the effect of an assisted dying decision

    - weigh up the factors referred to above for the purposes of making an assisted dying decision

    - communicate an assisted dying decision.

- As Sean has decision-making capacity, the Coordinating Doctor and Sean sign the First Request form. Sean then requests to proceed to the First Assessment process.

- As part of the First Assessment process, the Coordinating Doctor confirms with Sean's Consultant that Sean's life expectancy is more than 6 months.

- The Coordinating Doctor further discusses with Sean his wish for an assisted death and Sean's current level of suffering. Sean states that he is not currently in pain or suffering but is scared about what dementia is and how he will be in the future.

- Coordinating Doctor determines that Sean does not meet the eligibility criteria as Sean has more than 6 months to live.

- The Coordinating Doctor meets with Sean to explain the outcome of the assessment. Sean decides not to request a Second Opinion Assessment

- Coordinating Doctor signpost Sean and his care worker to additional support including from Dementia Jersey.

Summary of key safeguards

- The Law allows practitioner to raise subject of assisted dying
    - Although Sean does not use the term 'assisted dying' he clearly wanted to discuss the subject. The law did not prohibit the GP from explaining the term, which the GP did in accordance with the published Appropriate Conversations guidance.

- Extended team and specific capacity assessment
    - The extended team included a nurse who specialises supporting patients with learning disabilities, who carried out a capacity assessment

- Option for second opinion assessment
    - Sean was assessed as ineligible for assisted dying, but was offered the option of a second opinion assessment, which he declined

- Signposting for additional support
    - Sean's request for assisted dying was motivated by fears and concerns around his dementia diagnosis. Whilst ineligible for assisted dying, Sean was signposted to additional support.

Person 4

- Claire is 42 years old, married with 3 children under 10 years old
- Lives in a private residence with her family
- Has been recently diagnosed with stage 4 metastatic breast cancer
- In receipt of residential palliative care (at a Hospice)

Possible safeguarding considerations

- No specific concerns but Claire is at the end-stage of the disease which may have an impact on pace and progression of the assisted dying process.

Circumstances / sequence of events

- Claire is close to the end of life and experiencing a great deal of pain and suffering. At her request, Claire's husband directly contacts the Jersey Assisted Dying Service. A Coordinating Doctor is assigned, and Claire states she wishes to make a first request during a video call. The Coordinating Doctor then attends Claire at the Hospice and she signs the First Request form in person. She requests the assessment process to begin as soon as possible.

- The Coordinating Doctor attends Claire again to start the assessment process. During the appointment the Coordinating Doctor assesses Claire's decision-making capacity

and whether her wish for an assisted death is voluntary, clear, settled and informed. The Coordinating Doctor determines she meets the criteria and informs Claire. The Coordinating Doctor is of the opinion that Claire has less than 14 days to live.

- Independent Assessment Doctor carries out separate assessment with Claire two days after the first assessment. The Independent Assessment Doctor also determines that Claire meets the eligibility criteria and that her life expectancy is less than 14 days.

- On the same day the Coordinating Doctor meets with Claire who makes a second request for assisted dying, signed by an independent witness.

- The Coordinating Doctor then completes the Administrative Review and Claire is informed that her request is approved and that she may proceed to the planning stage for her assisted death, given her short life expectancy, she is not required to wait the full 14 days prior to having the assisted death.

- The Coordinating Practitioner agrees to take on the role of Administering Practitioner and, at Claire's request, carries out the Care Plan meeting directly after granting approval.

- The Hospice is not registered as a place where assisted deaths may take place. Claire decides that she would like to return to the family home and for the approved drugs to be administered by the Administering Practitioner.

- The Administering Practitioner, who with Claire's permission has been liaising with Claire's husband, has already checked that Claire's home is a suitable place and with the help of the Care Navigator, has liaised with the Hospice regarding transferring Claire home.

- As discussed with the Coordinating Doctor and Independent Assessment Doctor during the assessment process, given the progression of her illness, Claire may soon lose decision-making capacity. Therefore, she decides to sign a waiver of requirement for future capacity, so that the Administering Practitioner may proceed with her wishes, in the event she loses capacity.

- The Administering Practitioner and extended team nurse attend the home the day after the approval decision was made. The Administering Practitioner carries out final review of Claire's capacity, request for an assisted death and that the decision is voluntary. Claire's condition has deteriorated significantly in the past 24 hours and the Administering Practitioner determines she no longer has decision-making capacity. As she has a waiver of requirement for future capacity in place, and shows no signs of refusal, the Administering Practitioner may proceed with the assisted death.

- The AP administers the approved drugs intravenously and Claire's death is recorded 6 minutes later. The Administering Practitioner completes the Post-Death Administration Form, this includes details of the substance administered, time of administration and time of death, any medical complications or interventions taken. It also notes Claire did not have decision-making capacity but did have a waiver of requirement for future capacity in place.

- Assisted death takes place 7 days after first request.

Summary of key safeguards

- Right of premises owner to refuse to assisted dying on premises
    - The Hospice maintained the right to object to Claire's death on their premises

- Locations for assisted death are pre-approved as suitable for an assisted death
    - Claire's home is visited by the Administering Practitioner, prior to approving it as suitable location for assisted dying in Care Plan

- Pace of process determined by individual and minimum timeframe may be waived if life expectancy is less than 14 days
    - Claire chose to move through process as quickly as possible as she was at the end stage of her disease, both assessing doctors were of the opinion that she had a life expectancy of less than 14 days and so was able to proceed to an assisted death before the full 14 day period of reflection.

- Waiver of requirement for future capacity
    - Claire was assessed and approved as eligible for assisted dying with decision-making capacity. Given the rapid deterioration of her condition, she made the decision to sign a waiver of requirement for future capacity. On the day, Claire was found to have lost decision-making capacity, but the Administering Practitioner was able to proceed with the assisted death in accordance with Claire's wishes because of the waiver was in place. If Claire had shown signs of refusal or distress, the Administering Practitioner would not have proceeded despite the waiver being in place.

- Bereavement support for families
    - Although the family were supportive of her decision and considered this to be a positive choice, Claire's husband and young family were supported after her death.

Person 5

- Sonia, 47 years old, no children
- Lives with her partner
- History of intervention from Social Services and States of Jersey Police, previously spent time in temporary accommodation
- History of depression, previous in-patient in mental health unit
- Recent diagnosis of melanoma (skin cancer)
- Due to have surgery to remove the melanoma in 1 week.

Possible safeguarding considerations

- Coercion from partner who has history of physical and emotional abuse.
- Decision-making capacity impaired by mental health.

Circumstances / sequence of events

- Sonia attends her GP with her partner in attendance, she makes a request for assisted dying. The GP does not object to assisted dying but does not feel knowledgeable about the area. After a phone call to the Jersey Assisted Dying Service, and on the advice of the Care Navigator the GP refers Sonia to the Service.
- The Care Navigator calls Sonia later that day, her partner answers her mobile and reluctantly hands over the phone to Sonia. Sonia makes an appointment.
- Sonia's partner accompanies her to that initial appointment with the Coordinating Doctor, at which Sonia makes her first request for an assisted death. She then requests a first assessment, and her partner also attends this. Her partner speaks on her behalf for much of the session.
- The Coordinating Doctor informs them that, as part of the assessment process, the Doctor needs to speak with Sonia alone. When the partner is out of the room, the Doctor asks further questions to examine the voluntariness of the Sonia's decision.
- The Coordinating Doctor has spoken with Sonia's surgical oncologist in advance and explains to her that the prognosis is good if she undergoes surgery. Sonia nevertheless continues to state that she wants an assisted death.
- The Coordinating Doctor raises their concerns about coercion with the extended team including the social worker who carries out an assessment, which includes speaking with other family members (Sonia has given her permission for these conversations to take place). The social worker is of the opinion that Sonia's decision cannot be

confirmed as voluntary and free from coercion. Because of the doubts, the Coordinating Doctor determines she is not eligible for an assisted death.

- Sonia has a history of severe depression but during the assessment she does not exhibit signs of depression and because the Coordinating Doctor has already determined she is ineligible, a psychiatric assessment is not undertaken.

- The Coordinating Doctor meets with Sonia alone to explain the outcome of the assessment. The social worker is also in attendance.

- After much discussion she decides to undergo the surgery, she is also provided support by a women's support charity.

Summary of key safeguards:

- Eligibility criteria only allows for those who are making a voluntary, clear, settled and informed request
    - Sonia is assessed as ineligible, due to concerns about coercion by partner – her decision cannot be confirmed as voluntary.

- Extended team - social worker assessment
    - Supports assessing doctor with consideration of non-medical aspects of assessment, specifically around suspected coercion and voluntariness of decision – social worker carried out an additional assessment.

- Psychiatric assessment
    - Not used on this occasion as Sonia already ineligible, however due to history as in-patient in mental health unit, it is likely that assessing doctor would have requested additional mental health assessment prior to making a determination.

- Signposting for additional support
    - Sonia referred back into social services, due to vulnerable circumstances and supported by a local charity.

Person 6

- Annie, 29 years old, single
- Lives with parents
- Diagnosed with schizophrenia and severe depression aged 21

Possible safeguarding considerations

- Decision-making capacity impaired by mental health

Circumstances / sequence of events

- Annie mentions her wish for assisted dying during a consultation with her psychiatrist at one of their regular appointments.

- The psychiatrist advises Annie of the assisted dying eligibility criteria (having undergone basic training on the assisted dying legislation) and explains that Annie is unlikely to be found eligible as her suffering is a result of mental illness, not a physical medical condition.

- The psychiatrist also informs Annie that they conscientiously object to assisted dying but provides her Annie with the contact details for the Jersey Assisted Dying Service.

- Annie calls the Service and speaks with a Care Navigator who advises the same, but Annie is adamant that she still wants to make a first request. The Care Navigator arranges for Annie to meet a Coordinating Doctor.

- At their meeting, the Coordinating Doctor spends time with Annie discussing the reasons for her request as well as explaining again that she would not be eligible.

- At the end of the meeting Annie decides not to make a First request.

- The Coordinating Doctor and Care Navigator follow up with Annie's psychiatrist, with Annie's consent and an appointment is made with her psychiatrist to explore further care and treatment options.

Summary of key safeguards:

- Option for self-referral
    - The individual has option to self-refer if health care professional conscientiously objects. The professional does, however, have a duty under their professional code of practice not to obstruct the individual's wishes, so must inform them of the Jersey Assisted Dying Service.

- Right for health care professional to conscientiously object

    - Health care professional has right to conscientiously object and not participate in assisted dying, however as above, this does not extend to 'obstructing' the individual from accessing a service which goes against the professional's personal beliefs.

- Eligibility criteria does not allow for those with unbearable suffering due to mental illness only

- Annie may have been experiencing unbearable suffering, but under eligibility criteria set out in law, she would not be eligible as suffering must be a result of a *physical* medical condition.

- Signposting for additional support
  - Although Annie was ineligible, her suffering was significant, and as a result, she was referred back to her psychiatric consultant for additional support.

Person 7

- Clive, 62, divorced, 2 adult children (estranged)
- Lives alone in a large property
- Sole beneficiary of large inheritance from recently deceased father
- Diagnosed with Motor Neurone Disease (MND) 12 months ago
- In receipt of palliative care

Possible safeguarding considerations

- Coercion from adult children who have been back in touch with father following death of grandfather. They are aware of the large inheritance.

Circumstances / sequence of events

- Clive was diagnosed with MND a year ago. His brother-in-law had previously died from the disease and Clive had witnessed his suffering. Hence Clive had been thinking a great deal about assisted dying but had not yet discussed the matter with anyone.

- Clive's elderly father had recently died making him the sole beneficiary of a substantial inheritance. Clive had previously been estranged from his two adult sons, but those sons resumed contact on the death of Clive's father and quickly become fully immersed in Clive's life and care needs.

- Around a month after Clive's father's funeral, the sons raised the subject of assisted dying with Clive, explaining they think this would be best for him and offering to contact the Jersey Assisted Dying Service. Clive listens but does not share his own thoughts on assisted dying. He allows them to contact the Service on his behalf.

- Clive meets with the Coordinating Doctor to make a First Request and decides to start the assessment process. He does this alone. He talks the Coordinating Doctor through his experience of his brother-in-law and how he's coping with his symptoms. He also talks through his relationship with his sons and their recent reappearance in his life.

- As part of the First Assessment process, a Social Worker carries out an assessment, meeting with Clive and his sons both separately and together. The social worker's assessment acknowledges the complex family relationships and aspects of overly persuasive behaviour demonstrated by the sons. However, the social worker is confident that Clive's decision is voluntary and his wish for assisted dying pre-dates any involvement from his sons.

- The Coordinating Doctor requests an additional assessment from Clive's consultant. The outcome of this assessment is that Clive's life expectancy is no more than 12 months.

- As MND is a neurodegenerative condition – which means the 12-month life expectancy timeframe applies - the Coordinating Doctor determines that Clive meets the eligibility criteria for assisted dying.

- Clive requests a second assessment, during which the Independent Assessment Doctor reviews the relevant opinions requested by the Coordinating Doctor, then carries out separate independent assessment. The Independent Assessment Doctor also determines that Clive is eligible.

- Coordinating Doctor meets with Clive who makes a second request for assisted dying, signed by an independent witness.

- The Coordinating Doctor completes the review of request and approves Clive's request for assisted dying. Clive is informed that he may proceed to the planning stage for his assisted death when he chooses to (allowing for a minimum of two working days before the assisted death in the event of any appeal)

- An Administering Practitioner and Clive have an Assisted Death Care Plan meeting, at Clive's request, 1 week after he has been approved for assisted dying.

- Clive now uses a wheelchair and is exclusively fed via a feeding tube due to swallowing issues.

- The Administering Practitioner discusses Clive's options, he could still self-administer the approved drugs via his nasogastric tube (NG), or the practitioner could administer via NG or IV.

- Clive decides he want the approved drugs to be administered intravenously by the Administering Practitioner and that he wants to die at home, with his sons present.

- The Administering Practitioner and extended team member nurse attend the home on the agreed time and date, 5 days after the Assisted Death Care Plan meeting.

- The Administering Practitioner carries out final review of Clive's capacity, request for an assisted death and that the decision is voluntary, clear, settled and informed.

- The Administering Practitioner administers the approved drugs intravenously and Clive's death is recorded 11 minutes later. The Administering Practitioner completes the Post-Death Administration Form, this includes details of the substance administered, time of administration and time of death.

Summary of key safeguards

- Eligibility criteria only allows for those who have a terminal neurodegenerative condition with a life expectancy of 12 months or less
    - Although Clive has significant physical challenges and suffers greatly from the impact of his condition, he can request assisted dying whilst he still has capacity to do so.

- Assessment process, not single appointment
    - Clive is able to discuss his wish for assisted dying at a number of sessions with both assessing doctors, this allows them to determine that Clive's request for assisted dying is *voluntary, clear, settled and informed*.

- Extended team - social worker assessment
    - Additional social worker assessment considers family dynamic and rules out risk of coercion / non-voluntary request for assisted dying.

Person 8

- Otto, 91, widower, 2 children (both deceased), no close surviving relatives
- Lives in a residential care home
- No significant medical conditions, has type 2 diabetes and macular degeneration
- Feels disillusioned with life and has requested to die

Possible safeguarding considerations

- No immediate family.

Circumstances / sequence of events

- Otto is an older man who lives alone in a Residential Home. Whilst he is friends with other residents, he has no surviving immediate family. At a regular GP appointment, Otto says he is 'tired of life' and is 'ready to go'. He mentions assisted dying and the GP makes a referral to the Jersey Assisted Dying Service.

- A Care Navigator contacts Otto and arranges an appointment at which Otto can make his first request. The Coordinating Doctor attends the residential home for the appointment. They discuss Otto's circumstances, his health and living circumstances. The Coordinating Doctor explains the assisted dying process, including the requirement for either a terminal diagnosis or unbearable suffering due to physical health condition.

- Otto and the Coordinating Doctor complete the First Request Form and Otto indicates he wants a first assessment, which is arranged for the following week but postponed as Otto becomes unwell with pneumonia. Otto's condition worsens and he dies 3 days later.

- If Otto had had an assessment, he would have been found ineligible as he was 'tired of life' but did not have a terminal diagnosis nor was he experiencing unbearable suffering.

- In addition, the Residential Home had the right to refuse assisted dying on their premises. Whilst they permitted assessments on the premises, they did not permit assisted deaths. If Otto had been eligible for assisted dying, he would have to have been transferred to Jersey General Hospital for the assisted dying to go ahead.

Summary of key safeguards:

- 'Tired of life' not an eligibility criteria
    - Although Otto was not assessed for assisted dying, he would have been found to be ineligible on health grounds, given that at the time he had no terminal diagnosis, nor was experiencing 'unbearable suffering' due to a physical medical condition.

- Right of premises owner to conscientiously object to assisted dying on premises
    - Should Otto have been found eligible, the care home would have a right to refuse assisted dying on their premises, Otto would have been supported to be transferred to Jersey General Hospital (or another approved location) for his assisted death.

Person 9

- Sadie, 31, single
- Lives with parents
- Diagnosed with anorexia aged 15, has been treated as an in-patient in specialist UK units on 3 occasions
- Diagnosis of end-stage heart failure as a result of her anorexia

Possible safeguarding considerations

- May not have decision-making capacity.

Circumstances / sequence of events

- Sadie was diagnosed with anorexia as a teenager and has battled the disease for half her life. She also has end-stage heart failure as a result of her anorexia.

- During an appointment with her psychiatrist, Sadie expresses a wish for an assisted death. The psychiatrist explains that they object to assisted dying and will not it discuss with Sadie, but they give her an information leaflet so Sadie can make direct contact with the Jersey Assisted Dying Service.

- The Coordinating Doctor meets with Sadie who makes a First Request for assisted dying. During the appointment they discuss Sadie's medical history, including her heart failure which is likely to be terminal, and her wish for an assisted death.

- As part of assessment process, the Coordinating Doctor seeks advice from her cardiologist who confirms that Sadie's condition is terminal and there is a reasonable expectation she will die within 6 months.

- A specialist from the UK carries out a psychiatric assessment. At this stage it is determined that Sadie has decision-making capacity.

- At the end of the first assessment process the Coordinating Doctor determines that Sadie is eligible for assisted dying, because of her heart failure.

- Sadie requests her second assessment two weeks later. The Independent Assessment Doctor reviews the first assessment, then carries out separate assessment. The Independent Assessment Doctor meets Sadie in person and is concerned that Sadie's mental health condition has notably deteriorated. The Independent Assessment Doctor requests a second psychiatric assessment.

- At this appointment the specialist from the UK confirms that Sadie's mental health has deteriorated and is of the opinion that she no longer has decision-making capacity

- As a result of this, the Independent Assessment Doctor determines that Sadie is ineligible for assisted dying, as she does not have decision-making capacity.

- Sadie requests a second opinion; a Second Opinion Doctor is appointed who carries out a Second Opinion Independent Assessment. The Second Opinion Doctor reviews the previous assessments, meets with Sadie, the Coordinating Doctor and discusses the additional assessments with the UK psychiatrist. Based on their independent assessment of Sadie, the Second Opinion Doctor determines that Sadie is not eligible for assisted dying on the grounds that she does not have decision-making capacity.

- Sadie accepts the decision of the Second Opinion Doctor. Sadie dies two months later following a cardiac arrest.

Summary of key safeguards

- Eligibility criteria allows for assisted dying on basis of a terminal diagnosis of a physical medical condition, but not a mental illness
    - Sadie may have been experiencing unbearable suffering as a result of her anorexia, but under eligibility criteria set out in law, she would not be eligible on these grounds as suffering must be a result of a *physical* medical condition.

    - However, a secondary physical medical condition (i.e., heart failure) meant she could have been eligible for assisted dying.

- Eligibility criteria requires decision making capacity at each stage of the process
    - Whilst Sadie was assessed as having capacity during her first assessment, her mental health deteriorated and, when it was re-assessed at the independent second assessment, she was found to no longer have decision-making capacity.

- Independent assessment by 2 doctors
    - Her medical diagnosis and decision-making capacity, was scrutinised by two doctors, as one of the doctors determined she did not meet the eligibility criteria, she was ineligible for assisted dying.

- Option for two psychiatric assessments, given her serious mental health condition and worsening of condition during the assessment process
    - Additional assessments can be undertaken as part of the first assessment by the Coordinating Doctor, and as part of second assessment by the Independent Assessment Doctor. Given the change in circumstances, it was appropriate for Sadie to have two separate psychiatric assessments to determine her eligibility.

- Right to Second Opinion
    - Sadie was able to request a second opinion, following the Independent Assessment which found her to be ineligible. In this instance, the Second Opinion Doctor also determined her to be ineligible. But should they have found her to be eligible, following final administrative review by the Coordinating Doctor, she would likely have been approved for assisted dying.

Professional 1

- Seb aged 23, working as a healthcare assistant for a domiciliary care agency
- Seb's mother died of cancer 18 months ago, he is struggling with the loss and is undergoing bereavement counselling
- He had not previously given much thought to assisted dying, and does not have a strong view as to whether or not assisted dying should be permitted

Right to refuse/ protections for professionals - considerations

- no right to refuse to provide ongoing care for patients considering an assisted death
- right to refuse giving a relevant opinion and being present for assisted death

Circumstances / sequence of events

- Seb participated in the online training for health and care professionals prior to the introduction of the assisted dying law.
- The law has now been in effect for 6 months and a client that he cares for (Mrs Rondel) has decided to request assisted dying given her prognosis of less than 6 months as a result of pancreatic cancer
- The circumstances of Mrs Rondel's condition bear a number of similarities to Seb's mother's illness. This has an impact on Seb who finds it hard to provide care for Mrs Rondel to his usual standards.
- After Mrs Rondel informs Seb that she has had her first assessment for assisted dying, Seb speaks with the agency manager about his 'right to refuse' and asks to no longer provide care for Mrs Rondel. He understands that 'right to refuse' goes beyond 'conscientious objection' that is to say, Seb is not morally or ethically against assisted dying, but rather he finds the current circumstances difficult.
- Claire, his manager, informs Seb that the 'right to refuse' as set out in the assisted dying law, does not provide a right to refuse providing any usual care or treatment to a person, that is not related to the assisted dying process.

- She goes on to explain that things that would be covered by a right to refuse include providing a 'relevant opinion' about the individual, if asked to do so by an assisted dying practitioner or being present when the individual is being administered the drugs- e.g. when the assisted death is taking place.

- Seb now understands this and following further discussion with Claire, she decides to rearrange the rota in the interest of Seb's wellbeing, so that Seb does not have to provide care for Mrs Rondel, even though it is not a right provided to him under the law.

Professional 2

- Sarah aged 54, working as a ward nurse for Health Care Jersey
- Describes herself as having a strong faith, and is active in her local church community
- Has not actively campaigned against assisted dying, but receives updates from campaigning groups opposed to assisted dying and has attended a number of public meetings organised by UK and local campaigning groups

Right to refuse/ protections for professionals - considerations

- right to refuse to participate in assisted dying training

- no right to refuse to provide ongoing care for patients considering an assisted death

Circumstances / sequence of events

- Sarah has been troubled about the introduction of assisted dying, having connected with groups of healthcare professionals who are opposed to the law.

- She is concerned that it is in opposition to core elements of her faith and she has concerns about the impact on vulnerable, older patients who may feel pressured into requesting assisted dying.

- In preparation for the law coming into effect, she has been invited by her team lead to participate in online training about the law.

- The training module covers:
    - key aspects of the law, including the eligibility criteria and key steps in the process
    - detail about protections for professionals, including the right to refuse to participate
    - how to have appropriate conversations with patients, and what to do if a patient raises the subject of assisted dying

- Sarah does not feel comfortable about this, and is of the view that undertaking the training is, indirectly, supporting the introduction of the law
- She raises this with her manager, Robin, who has already undertaken the training. Robin explains to Sarah that the training is not mandatory, and that under the assisted dying law she has the right to refuse to participate in the training.
- Robin goes on to explain that the assisted dying law also provides protections for professionals, which means that Sarah cannot be treated unfairly in her role as a result of her views towards assisted dying or because she chooses to refuse to participate in assisted dying (including training).
- This means, for example, she could not be denied a promotion on the grounds that she did not participate in the assisted dying training.

Professional 3

- Sam aged 42, working as a GP in a local GP partnership for past 3 years, since moving to the Island
- Has applied for a role at Jersey Assisted Dying Service, alongside his regular surgery work.

Right to refuse/ protections for professionals - considerations

- employment and partnership protections for involvement in assisted dying

Circumstances / sequence of events

- Sam has enjoyed a good working relationship with his colleagues and partners at his GP surgery since moving over from the UK three years ago.
- Sam believes it is important to support patients to make informed decisions about their health and care choices. He has decided work for the Assisted Dying Service as a he is supportive of patient autonomy and has an interest in end-of-life care, but would not consider himself to be a campaigner for assisted dying.
- He has applied to undertake the assisted dying practitioner training and register to become a Coordinating Doctor, assessing individuals for their eligibility for assisted dying.
- Sam meets with the other surgery partners to inform them of his decision. He intends to work for Assisted Dying Service 1 day per week, alongside his regular work at the surgery. He informs them this would not impact on the workload he currently undertakes for the surgery.

- One of the senior partners expresses concern about this, stating that assisted dying is not in line with the values of the partnership. Given the seniority of that partner, other partners side with their view and ask Sam to reconsider or he will be asked to leave the partnership.

- Following the meeting, Sam contacts his legal representation who confirms that the assisted dying law provides protections for employment and partnerships, and he cannot be expelled from the partnership or suffer any other detriment (such as being offered less favourable terms and conditions) as a result of his involvement in assisted dying.

- Sam informs the partnership of this, who also seek legal advice. Following this, the partnership reconsiders their position and inform Sam that he is able to pursue additional employment with the Jersey Assisted Dying Service, providing that it is in accordance with his existing contractual arrangements.

- Sam does this and goes on to work as a Coordinating Doctor at the Assisted Dying Service for a 3-year period whilst continuing work with the GP partnership, before moving on to set up a new surgery with his wife, who is also a doctor.

APPENDIX 4 TO REPORT

Summary comparison between UK Terminally Ill Adults (End of Life) Bill clauses and Jersey draft law

1. Proposals to introduce assisted dying in England and Wales are currently being debated by the UK Parliament. The Terminally Ill Adults (End of Life) Bill is due to have its second reading in the House of Lords in September, having passed through the House of Commons.[37]

2. The table below provides a high-level overview of the clauses in the UK Bill, noting where there are similar provisions in the Jersey draft law and providing a brief explanation of this or setting out key differences, if applicable.

3. The table is intended to be read alongside the UK Bill and the draft Jersey law, not as a standalone document.

Summary of UK Terminally Ill Adults (End of Life) Bill and Jersey draft assisted dying law comparison				
Clause no.	**UK Bill clause**	**Similar provision in Jersey Draft law?**	**Reference to relevant article in Jersey draft law, if applicable**	**Notes**
1	Eligibility criteria	Yes	2	Both have requirements of: 18+, ordinarily resident for 12m+ at point of first request, capacity requirement. Jersey law has no requirement to be registered with GP, but in practice individual unlikely to approved as eligible without it, due to assessment requirements under draft law.
1	Eligibility criteria	Yes	2	nature of wish - 'clear, settled and informed wish' and 'voluntary decision' as per Jersey law - i.e. absence of coercion as per Jersey draft law
2	Terminal illness	Yes	2	6 months life expectancy (but no 12-month time period for neurodegenerative conditions in UK Bill)
3	Capacity	Yes	24	UK Bill capacity requirement linked to UK Mental Capacity Act 2005, not a specific test in assisted dying law, as is the case in Jersey draft law
4	Assisted Dying Commissioner	No	Part 3, Division 3 & Division 5	No commissioner in Jersey model, but oversight provided through Assurance and Delivery Committee with independent chair, post-death review

[37] Terminally Ill Adults (End of Life) Bill

				panel and independent regulation by JCC
5	Preliminary discussions with registered medical practitioners	Yes - partial	60	As per UK Bill, Jersey draft law does not require or prevent professionals from raising issue of assisted dying with patients. Concept of 'preliminary discussion' in UK Bill, not present in Jersey law because function of 'initial discussions' are covered by assisted dying service model where patients are referred into Service or self-refer for a preliminary discussion prior to making first request. Also exists through requirement on Committee to develop 'appropriate conversations guidance' for all professionals
6	No discussion with person under 18	No		As above, Jersey draft law is 'silent' on discussions, but consideration will be given as to whether guidance will stipulate discussions with those aged under 18 who are terminally ill are not permitted
7	Recording of preliminary discussions	No		As above, handled via Service in Jersey model, Service will record referrals and self-referrals into Service, as per the 'pre process steps' set-out in P.18/2024 [see paras 204 to 216]
8	Initial Request	Yes	3	UK Bill similar to Jersey draft law in that it requires individual to meet initial eligibility - e.g. age and residency. UK Bill requires additional witness to Coordinating Doctor, Jersey draft law requires this for 2nd request only, as agreed by P.18/2024.
8	Requirements for Coordinating Doctor	Yes	78	UK Bill has some similarities to Jersey requirements (mandatory training, no conflict of interest with individual), but Jersey has additional requirement that doctor must register as an assisted dying practitioner. Jersey draft law sets out training requirement for coercion, but doesn't set out training requirement for reasonable adjustments, but training outline and competencies framework is anticipated to do so.
9	Witnessing first declaration	No	6	As above, features in Jersey law at second request
10	First assessment	Yes	4	Both jurisdictions provide for first assessment by Coordinating Doctor
11	Second assessment	Yes	5	Both jurisdictions provide for second assessment by Independent Assessment Doctor

12	Doctors' assessments	Yes	5, 6 29 & 26, 27+ Schedule 1	As per UK Bill, Jersey draft law includes duty to inform the individual of certain matters [see Art 26 + 27 & Schedule 1] and advise them to inform their GP and family members [if appropriate] Jersey draft law permits assessing doctor to determine which professional is most appropriate to provide a relevant opinion / assessment of the individual
13	Second opinion assessment	Yes	30 & 31	In UK Bill second opinion available only after independent assessment, in Jersey draft law is available after first and/or independent assessment
14	Replacing the Coordinating Doctor	Yes	33	As per UK Bill, Jersey draft law also allows for change of practitioner, if the original one is unable to continue
15	Replacing the coordinating or independent doctor	Yes	33	As above
16	Referral by Commissioner of case to multidisciplinary panel	N/A		No Commissioner or multidisciplinary panel in Jersey model
17	Determination by panel of eligibility for assistance	N/A	7	However, process is similar to Step 5 in Jersey model 'review and decision on request for assisted dying' carried out by the Coordinating Doctor
18	Reconsiderations by panel	Yes - partial	40	Jersey model has similar effect, but mechanism is by appeal to Royal Court
19	Second request	Yes	6 and 9(1)(d)(i)	Jersey draft law also has witness requirement at this step. UK Bill has period of reflection here. Jersey law has 14-day period of reflection from first request to final review prior to administration of drugs
20	Cancellation of declaration	Yes	15	As per UK Bill, Jersey draft law allows for withdrawal of request at any point in process
21	Signing by proxy	Yes	16	As per UK Bill, Jersey draft law allows for forms to be signed by proxy, if individual is physically unable to sign themselves
22	Independent advocate	Yes	1, 21, 60, 76	Jersey draft law requires Service to arrange for provision of independent advocates and Coordinating Doctor to arrange for advocacy support to be provided to individual during assisted dying process, if required. Duty on Committee to produce operational guidance on the provision of advocacy. As per UK Bill, Jersey draft law includes regulation-making power for independent advocacy.

23	Recording of declarations, reports	Yes	19	Jersey draft law places duty on Service to hold all assisted dying forms in the individual's records
24	Recording of cancellations	Yes	15	Duty on Coordinating Doctor to tell any connected person or practitioner (for example GP, if involved) that they have withdrawn from the process
25	Provision of assistance	Yes	9 to 12	Similarities between UK Bill & Jersey draft law: Approved drugs may only be provided directly to the individual and must remain nearby the individual during administration and final review by doctor prior to administration. Administering Practitioner may be accompanied by another professional. However, UK Bill does not allow for practitioner administration (self-administration only), but does allow professional to assist individual to ingest the drugs and in Jersey draft law, Administering Practitioner may be a doctor or a registered nurse (but both need to be registered as an assisted dying professional which is not a requirement in UK Bill)
26	Authorising another doctor to provide assistance	N/A		Jersey process differs in that it need not be the Coordinating Doctor who supports individual to administer, there is separate role of Administering Practitioner which can be same as Coordinating Doctor or another assisted dying practitioner, so equivalent to this clause is not required in Jersey draft law.
27	Meaning of 'approved substance'	Yes - partial	56	Both jurisdictions require specific drugs to be approved for purpose of assisted dying - UK Bill requires Secretary of State to approve drugs by regulations, the Jersey draft law sets out that the Delivery and Assurance Committee must approve the drugs and consult relevant organisations before doing so.
28	Final statement	Yes	13 (& 7)	Both jurisdictions require the 'administering practitioner' to provide details about the assisted death and the individual (in Jersey this is also covered in part by Art 7)
29	Report where assistance not provided	Yes	11	Both jurisdictions require 'administering practitioner' to complete form where assisted death does not take place - either due to practitioner not being satisfied that individual continues to meet criteria or individual withdraws request (as below)

30	Other matters to be recorded	Yes	15	Both jurisdictions require 'administering practitioner' to complete form where assisted death does not take place
31	No obligation to provide assistance	Yes	34, 35 & 36	Both jurisdictions set out right to refuse and employment protections for employees
32	Criminal liability for providing assistance	Yes	41	Both jurisdictions set out that a person does not commit an offence if performing a function under the law
31	Civil liability for providing assistance	Yes	41	Both jurisdictions set out that person cannot be held liable in a civil court if performing a function under the law
34	Dishonesty, coercion or pressure	Yes	43	Both jurisdictions create the offence of coercion. In addition, Jersey draft law also makes it an offence to coerce someone to *withdraw request* for assisted dying
35	Falsification or destruction of documentation	Yes	44	In Jersey draft law, this is covered by 'Offence to give false or misleading information or forge document' and is not a separate offence, however Jersey has additional offences relating to 'purporting to act as an assisted dying practitioner'
36	Falsification with intent to facilitate provision of assistance	Yes - partial	44 & 45	As above
37	Regulation of approved substances and devices for self-administration	No	56, 32 & 60	As per cl 27 - both jurisdictions require specific drugs to be approved for purpose of assisted dying - UK Bill requires Secretary of State to approve drugs by regulations, the Jersey draft law sets out that the Delivery and Assurance Committee must approve the drugs and consult relevant organisations before doing so. Art 32 of Jersey draft law provides detail on the prescribing, preparation and dispensing of approved drugs. Jersey draft law has requirement for Committee to provide operational guidance on prescribing and dispensing approved drugs and administering approved drugs.
38	Investigation of deaths etc.	Yes	Schedule 3 (3) and Art13	Similar to the UK Bill, Jersey draft law will provide consequential amendment to Inquests and Post-Mortem Examinations (Jersey) Law 1995, so that the Viscount need not be notified of an assisted death if carried out in accordance with the assisted dying law. Certifying doctor will certify the fact and cause of the assisted death, which

				will include illness that made individual eligible for assisted death.
39	Codes of practice	Yes	27, 60 & 61 & Schedule 1	Covered in Jersey draft law by operational and general guidance and includes requirement to consult relevant bodies. Information for the individual in Jersey is covered under 'specific information' at Art 27 and general information about assisted dying under schedule 1
40	Guidance about operation of Act	Yes	61 & 61	as above
41	Voluntary assisted dying services: England	Yes	Part 3, Division 4	In Jersey, draft law detail about Service and its functions is set out in primary legislation, UK has still not confirmed what Service will look like and who will provide Service e.g. NHS or commissioned externally
42	Voluntary assisted dying services: Wales	Yes	Part 3, Division 4	As above
43	Prohibition on advertising	Yes	48	In Jersey draft law this is set out as a specific offence
44	Notifications and provision of information to Commissioner	N/A	77	No Commissioner in Jersey model, but Jersey draft law requires information to be provided to Review Panel and JCC
45	Information sharing	Yes	77 & 39 (+ 70 & 85)	Committee may disclose information to JCC and UK regulatory bodies -e.g. General Medical Council, Nursing and Midwifery Council etc. for purposes of investigation of a professional
46	Obligations of confidence	Yes	39	Art 39 of Jersey draft law sets out parameters for disclosure of information
47	Reporting on implementation of Act	No		Jersey draft law does not require reporting on implementation, this requirement in UK Bill came about following push back of implementation to 2029 or later.
48	Disability Advisory Board on the implementation and implications of the Act for disabled people	No		Jersey draft law does not require establishment of advisory board, but work being undertaken with groups who represent disabled islanders regarding collaboration during the implementation period, and how to include voice of disabled islanders in set up of Service.
49	Monitoring by Commissioner	N/A	Art 72 & Part 3, Division 5	No Commissioner in Jersey model, but Review Panel will monitor each individual assisted death & processes that end before an assisted death, plus additional reporting detail provided in annual report (Art 72)

50	Review of this Act	No	72, 73 & Part 3, Division 5	Decision not to include 5 year review, as per phase 2 public consultation on assisted dying, as set out - a fixed review period could have the effect of delaying legislative changes, if any changes are required that need to be addressed in the immediate term or conversely, may be too restrictive and if a longer time period were required before legislative changes were to be made - or in the event that no changes may be required. Monitoring of the law will be achieved via Committee's annual reporting requirements. Minister may also request additional reports, including a review and Committee may report to the Minister on any matter. In addition, the Review Panel will review all assisted deaths and undertake analysis of trends across multiple assisted deaths and assisted death requests that did not result in an assisted death.
51	Provision about the Welsh language	N/A		
52	Disqualification from being a witness or proxy	Yes	16 and 17 (6)	In Jersey draft law the proxy who physically signs the form at the request of the individual may be related to the individual, but the witness may not (nor related to any assisted dying practitioner involved in the process, nor be set to benefit from the individual's death)
53	Power to make consequential and transitional provision	Yes	Schedule 2	Schedule 2 will provide for transitional provisions
54	Regulations	Yes	94	Regulations in Jersey draft law set out in Art 94
55	Duty to consult before making regulations	No		Not explicitly provided for in Jersey draft law, but consultation with relevant bodies would take place as part of process of bringing regulations to the States Assembly, and would be subject to usual Scrutiny process
56	Interpretation	Yes	1	Interpretations at Art 1 in Jersey law
57	Extent	N/A		
58	Commencement	Yes	100	Citation and commencement at Art 100 in Jersey law
59	Short title	Yes	100	Citation and commencement at Art 100 in Jersey law

APPENDIX 5 TO REPORT

List of safeguards

Safeguarding objectives

1. There are five key safeguarding objectives. To ensure:

    a. only those who meet the eligibility criteria set out in law are approved for an assisted death

    b. all islanders are protected and supported throughout the assisted dying process, including:

        - Islanders who may be coerced or pressured into requesting assisted dying
        - people with mental health conditions and / or those who do not have decision-making capacity
        - family members and loved ones of the individual requesting an assisted death
        - continuing ongoing support, care and treatment for individual whilst requesting an assisted death and on the assisted dying process

    c. assisted dying practitioners act in accordance with guidance and law

    d. professionals are supported and protected when acting in accordance with guidance and law, regardless of their position on assisted dying

    e. The Assisted Dying Service is safe and of high quality.

2. The safeguard associated with each of those objectives is described below. There is significant overlap between objectives.

Safeguarding objective 1: Eligibility criteria compliance

3. There are clear eligibility criteria set out in law including:
    a. health criteria (those with a terminal illness with a life expectancy of 6 months or less, or 12-months for those with a neurodegenerative condition)
    b. capacity criterion (individual must have capacity throughout the process)
    c. decision criteria (voluntary, clear, settled and informed request)
    d. age criterion (aged 18 or over)
    e. residency criterion (Jersey residents only)

4. There is no Regulation-making powers to amend the criteria, any future changes would require a primary law change.

5. There is a requirement for two assessments by two doctors to ensure compliance with eligibility criteria. The assessments are independent of each other. This is followed by a further review and decision on the request by the Coordinating doctor.

6. The assessing doctors are required to ensure that the individual is aware of all other treatment and care options, prior to confirming the individual's eligibility for assisted dying.

7. The extended team (multi-disciplinary) and relevant opinions are required where an assessing doctor is not able to reach a determination about elements of the eligibility criteria, including:

   - the decision-making capacity of individual; this can include additional assessment by social worker, nurse or psychological / psychiatric assessment etc, where appropriate

   - the request is voluntary, clear, settled and informed: this can include additional assessment by social worker or information from other agencies, where appropriate (in addition to discussion with family and friends)

   - eligibility on health grounds – e.g. prognosis: this can include advice or assessment by a treating consultant or consultant with expertise in that medical condition.

8. The individual has right to request an additional assessment by Second Opinion Doctor.

9. There is provision for appeal to the Royal Court, by the individual and those with special interest in the person's health and care.

<u>Safeguarding objective 2: Protecting and supporting all islanders</u>

10. Assisted Dying Service will provide information and support for all Islanders on assisted dying, including online and printed information materials.

11. The individual requesting assisted dying can self-refer to the Assisted Dying Service or be referred by a healthcare practitioner. Their ability to access the Service is not restricted by a professional referral requirement.

12. The law will allow the practitioner to raise subject of assisted dying, which helps supports equality of access. There will be training and guidance for all health care practitioners to support *appropriate* conversations around assisted dying.

13. There will be provision for interpreters / communication and / or advocacy to support an individual who has requested assisted dying.

14. The law acknowledges that an individual has right to privacy – family members or other attending practitioners or carers do not have to be informed of an individual's assisted dying request however, the individual is *encouraged* to notify family and other attending

practitioners or carers. It must be explained to the individual that their right to not inform others might impact an assessing doctor's ability to determine eligibility.

15. The pace and progression of the request, assessment, approval and delivery process is determined by the individual, who must request to proceed to each step of the process and has the right to pause the process, or withdraw their request at any point.

16. Minimum timeframes – a 14-day period of reflection is built into process, from first request to final review prior to administration of the approved drugs.

17. The 14-day timeframe may be overridden IF individual has life expectancy of less than 14 days, to prevent further suffering to individual, however, individual must still be fully assessed and meet all the eligibility criteria to be approved for assisted dying.

18. The individual requesting assisted dying must demonstrate decision-making capacity throughout the process and must also demonstrate that their request for an assisted death is voluntary, clear, settled and informed.

19. The 'request to proceed' arrangements provide an additional series of 'anti-coercion' safeguards, requiring the assessing doctors to consider the possibility of coercion during each step in the process, and as the individual transitions between steps. This is important because, if an individual delays transition to the next step, there may be underlying hesitancy that needs examination.

20. The extended team and relevant opinions are available to the assessing doctors to support a determination of:

- the decision-making capacity of the individual – including additional psychological / psychiatric assessment, if individual's presentation or medical history suggests their mental health may impact on their decision-making capacity

- the nature of the request i.e., that it is voluntary, clear, settled and informed (for example, an extended team social worker may undertake an assessment to explore possibility of pressure or coercion).

21. The assessing doctors are required to ensure the individual is aware of all other treatment and care options, prior to confirming eligibility for assisted dying.

22. The Assisted Dying Person Record (i.e., the single record for each individual requesting an assisted death) ensures that all information relating to the request is held securely and confidentially in one place.

23. The individual's ongoing care and treatment continues throughout the process and is not affected by their request for an assisted death. This includes, but is not restricted to, any palliative or end of life care and treatment they are receiving.

24. There will be signposting and support for those who are assessed as not eligible for assisted dying, including onwards referral to specific services if any safeguarding concerns or additional social care needs are identified.

25. The individual's wishes for their assisted death (for example, place of death and mode of administration) are discussed throughout assessment process and confirmed in their care plan. This includes matters related to presence and / or involvement of family and loved ones.

26. The individual can provide advanced consent not to receive life-saving treatment (e.g., resuscitation) and also provide advanced consent to the administration of additional approved drugs in the event of medical complications such as regurgitation, vomiting, or seizures.

27. A waiver of requirement for future capacity allows an individual's assisted death to proceed if they lose decision-making capacity after approval of their assisted dying request but before delivery of an assisted death, however:

- if a Waiver is not in place, and individual has lost decision-making capacity, the assisted death cannot proceed

- If a Waiver is in place but individual is showing signs of refusal or resistance at the point of administration, the assisted death cannot proceed.

28. There is no expiry of the approval for an assisted death to ensure that pressure is not placed on the individual to end their life if they are not ready to do so.

29. The Administering Practitioner, and the other professional present at the delivery of assisted death, oversee the administration of medication and are present to deal with any complications that may arise. The presence of two professionals enables support to be provided to any family members or loved ones who are in attendance.

30. Family members and friends may access wellbeing and bereavement support.

31. The Assurance and Delivery Committee oversees clinical governance, service safety, and quality.

Safeguarding objective 3: Practitioners act within the law

General

32. Health professionals have to 'opt in' to working for the Jersey Assisted Dying Service, which must maintain an up to date register of those professionals. They must all have undergone mandatory training prior to registration, which will include training on legal provisions. Training must be renewed every three years.

33. The Assisted Dying Service will be regulated and inspected by the Jersey Care Commission. This will ensure independent oversight of compliance with service standards and legal provision.

34. The draft law provides a range of offences that act as deterrent to anyone who intentionally acts outside of the law (this includes professionals and other people, such as family members). Offences include, for example, administering the approved drugs if you are not authorised to, or making a false statement. The offences would not apply to a professional who unknowingly carries out an act in good faith.

35. Involved professionals must complete a declaration of interest form to confirm they are not related to the individual making a request for an assisted death, nor set to gain from their death (e.g., a beneficiary of their will).

Request, assessment and approval

36. There are two separate assessments carried out by two assessing doctors (who are trained to provide individual clinical judgement on eligibility). The assessments are independent of each other.

37. The Independent Assessment Doctor is required to declare any interests in relation to the Coordinating Doctor, if any interests may conflict, or be seen to conflict, with their ability to undertake an independent assessment of the individual they may not act as the Independent Assessment Doctor.

38. The extended team will provide legitimate professional challenge to the assessing doctor's decision-making. This will help improve practice, provide cross-discipline consideration and ensure assessments are not reliant on a 'lone doctor'.

39. Relevant opinions are required where an assessing doctor is not able to make a determination about:
    - the decision-making capacity of individual
    - the voluntary, clear, settled and informed nature of request
    - eligibility on health grounds – e.g. prognosis.

40. The Second Request form must be signed by the individual and the Coordinating Doctor in the presence of an independent witness, who knows the individual sufficiently well to be able to attest to the fact that they are acting freely in making their second request.

41. The Coordinating Doctor must undertake an administrative review after completion of both assessments to ensure all documentation is complete and all steps in the process have been complied with prior to making a final approval decision.

42. A post-death review will be undertaken for every assisted death to determine adherence to guidance and legislation.

43. The Assisted Dying Person Record will be a singular record management system for all assisted dying requests, assessments and other recorded information, enabling better oversight and governance across the Service, including oversight of caseloads of individual assisted dying professionals, which may be reviewed by the Assisted Dying Review Panel.

Delivery of assisted death

44. The Prescribing and Dispensing Guidance ensures a clear chain of responsibility over the approved drugs from pharmacy to administration of substance.

45. Administering Practitioner and an administration witness will be present at the assisted death i.e., there is no lone practitioner. The administration witness will in most cases be another member of the Assisted Dying Service who can also support the Administering Practitioner in clinical matters (e.g.: setting up IV lines) if they are clinically qualified to do so.

46. The individual must provide final consent prior to administration of substance, which will be recorded on the Final Consent and Review form.

47. The Administering Practitioner will carry out a final review prior to administration of substance. If the individual does not have capacity (and no waiver of requirement for future capacity is in place) or the individual is not making the decision voluntarily, the assisted death cannot proceed. If a waiver of requirement for future capacity is in place but the individual is showing signs of refusal or resistance, the assisted death cannot proceed.

48. The person will have made a decision in their Care Plan whether to provide advance consent not to receive life-saving treatment (e.g., resuscitation), and consent to for the Administering Practitioner to administer additional approved drugs in the event of medical complications. This provides clarity to the Administering Practitioner as to what actions can be taken in the event of medical complications.

49. The administration witness will be required to certify that they witnessed the Administering Practitioner administer the approved drugs to the person (this will be recorded on the post-death administration form).

Post-death and governance

50. A Medical Certificate of Fact and Cause of Death (MCFCD) must be completed by a certifying doctor. The certifying doctor is a doctor who is independent of the Assisted Dying Service and who attended the individual within 14 days prior to their death.

51. The post-death review, which must be undertaken after all assisted deaths, can support the Assisted Dying Review Panel to identify concerns or suspected malpractice.

52. Role of Assurance and Delivery Committee to:

- oversee establishment of service (development of training & protocols)

- oversee delivery of Assisted Dying Service including:
    - development of, and assurance of compliance with, clinical standards
    - development of service standards, including target maximum timeframes for the Jersey Assisted Dying Service
    - oversight of service safety and quality, through continuous monitoring of the service
    - oversight of the management and response to complaints and / or potential patient safety concerns related to the service
    - providing assurance to the Minister and the public about patient experience, clinical safety and service quality
    - approving the retention schedule for all records held by the Jersey Assisted Dying Service
    - producing and publishing an annual report on assisted dying in Jersey
    - establishment of an Assisted Dying Review Panel

53. In the event of safety concerns, the Assisted Dying Complaints Policy will set out the procedures for responding to concerns, both in term of HCS processes and any escalation to the JCC or the relevant UK professional regulatory body, in the instance of fitness to practise concerns.

54. Jersey Care Commission (JCC) will register the Assisted Dying Service and inspect the Service at least once every 12 months, including the option to carry out unannounced inspections. The JCC will have powers to cancel registration in the event of significant failures to comply with any conditions imposed on the Service.

55. Assisted Dying Assurance and Delivery Committee must publish the Assisted Dying Complaints Policy setting out clear processes for complaints and concerns by service users, or their family and other professionals

<u>Safeguarding objective 4: Practitioners are supported and protected when acting in accordance with guidance and law</u>

56. The law will provide a right for health professionals to refuse to participate in assisted dying on any grounds, including conscientious objection.

57. Health professionals have to ‘opt in’ to working for the Assisted Dying Service via the registration process. They cannot be compelled to register.

58. There will be wellbeing and peer support for all assisted dying practitioners and all other attending practitioners and carers (i.e., those professionals who are caring for an individual who requests assisted dying but are not involved in the process).

59. Assisted Dying Assurance and Delivery Committee to produce clear guidance on all aspects of process. This will be developed in consultation with key bodies, including UK professional membership and regulatory organisations who have oversight of the professional’s practice.

60. All assisted dying practitioners will need to undergo mandatory training, including members of the extended team. This will ensure they have the knowledge to work in the service. Training and guidance will also be available to all other health care practitioners. This will provide an outline of the law and the assisted dying process, including matters related to referral and appropriate conversations.

61. A witness required for individual's Second Request for assisted dying, confirms voluntary, clear, settled and informed nature of individual's request.

Delivery of Assisted death

62. Where the death takes place in a private residence, the Administering Practitioner must be accompanied by another professional (the administration witness) who will attend the delivery of the assisted death. The Administering Practitioner will not be a "lone operator".

63. The individual will, in most cases, have made a decision whether to provide advance consent not to receive life-saving treatment (e.g., resuscitation), and advance to consent to the administration of additional approved drugs in the event of medical complications. This provides the Administering Practitioner with clarity as to the individual's wishes and what actions can be taken in the event of complications.

64. The individual must provide final consent prior to administration of substance via Final Consent and Review form – with a witness.

Post-death and governance

65. Post-death assisted dying review of each death to determine whether, in each case, practitioner has acted with adherence to the legislation and guidance

66. Assisted Dying Review Panel to review:

    i. each assisted death
    ii. a sample of assisted death requests that did not progress to an assisted death
    iii. In order to determine:

        - proper adherence to the legislation and guidance

        - identify any process matters that may require improvement / change

Safeguarding objective 5: High-quality, safe service

Request, assessment and approval

67. The Assisted Dying Service provides clear written information to Islanders (including healthcare professionals) on assisted dying, including online and printed information materials

68. The Assisted Dying Service is overseen by a dedicated, independently chaired, Assisted Dying Assurance and Delivery Committee. The Committee's role will include:

- approval of guidance and protocols
- ensuring robust clinical governance
- ensuring oversight of service safety and quality

69. The extended team provides a collaborative forum for determination of assessments and related matters and supports the assessing doctors to make informed decisions

70. The Assisted Dying Person Record provides a singular record management system for all assisted dying requests, assessments and other recorded information, enabling better oversight and governance in each case.

71. Assessment Guidance will provide that assessment meetings should, as a matter of standard practice, should be in-person (i.e., not remote assessments via video link etc) with remote meetings and consultation by exception only (for example, a follow up consultation to discuss a particular issue).

72. The Assisted Dying Assurance and Delivery Committee will publish an Assisted Dying Complaints Policy – setting out a clear process for complaints and concerns by service users, or their family and other professionals. They will also monitor compliance against that policy.

Delivery of Assisted death

73. The Care Plan, completed by the Administering Practitioner and the individual will set out all matters related to the delivery of the assisted death, including

- the location (all locations must be pre-approved as suitable for an assisted death)
- mode of delivery (i.e., practitioner administered or self-administered with or without the support of family members)
- other key details, including who will be present

74. The Prescribing and Dispensing Guidance and Approved Drugs Administration Guidance will ensure a clear chain of responsibility over the approved drugs from preparation and dispensing at the hospital pharmacy to administration of the approved drugs, and safe disposal of any unused drugs.

75. The Administering Practitioner, and the other professional present at the delivery of assisted death, oversee the administration of medication and are present to deal with any complications that may arise.

Regulation

76. The Assisted Dying Review Panel must undertake a post-death review of every assisted death to determine adherence to guidance and legislation, and identify trends and opportunities for service improvement.

77. The Assurance and Delivery Committee will publish an Assisted Dying Annual Report setting out matters related to the numbers of requests, names of assisted death etc. This will include information related to demographic details, types of health condition, etc. All data will be published anonymously. The Medical Officer for Health will act as an independent adviser to agree on the data to be presented in that annual report and to agree on the methodology for compiling the data

78. The Assisted Dying Service will be registered and regulated by the Jersey Care Commission who: must undertake annual inspections of the Service; may undertake any number of unannounced inspections; will be provided powers to sanction or suspend the Service.

APPENDIX 6 TO REPORT

Human Rights Notes on the Draft Assisted Dying (Jersey) Law 202-

These Notes have been prepared in respect of the Draft Assisted Dying (Jersey) Law 202- (the "**draft Law**") by the Law Officers' Department. They summarise the principal human rights issues arising from the contents of the draft Law and explain why, in the Law Officers' opinion, the draft Law is compatible with the European Convention on Human Rights ("**ECHR**").

These notes are included for the information of States Members. They are not, and should not be taken as, legal advice.

The purpose of the draft Law is to provide for the assisted dying of someone who has a terminal illness, who is experiencing (or is expected to experience) unbearable suffering and who chooses to end their life with the help of a medical professional. The law sets out the eligibility criteria and process for assisted dying including the associated oversight mechanisms, regulatory requirements and essential safeguards.

The draft Law engages two rights under the ECHR: the right to life (Article 2); the right to family and private life (Article 8). The issues in respect of each of these rights, and the reasons why the draft Law is compatible with them, are set out below.

It may be noted at the outset that states have, in respect of some ECHR rights, positive obligations to uphold the rights of individuals. Article 1 of the ECHR provides that, "*The High Contracting Parties shall secure to everyone within their jurisdiction the rights and freedoms defined in Section I of this Convention.*" These positive obligations include positive obligations under Articles 2 and 8 of the ECHR to make provision to effectively protect those rights.

Article 2 and Article 8

The current prohibition on assisted dying in Jersey is not in breach of the ECHR. That is because neither Article 2 of the ECHR, which provides that "*Everyone's right to life shall be protected by law*" and that "*[n]o one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which the penalty is provided by law*", nor Article 8, which provides for the protection of private and family life, which has been held to include a right to personal autonomy, have to date been held to include a right to assisted dying: *Pretty v. the United Kingdom* App. No. 2346/02 Judgment 29.4.2002; *Daniel Karsai v Hungary* App. No. 3312/23, judgment of 2 September 2024.

However, the European Court of Human Rights has held that whilst Article 2 does not comprise a right to end one's life it does not prohibit decriminalisation of euthanasia: *Mortier v. Belgium* App. 78017/17 Judgment 4.1.2023, §§138-139. That conclusion built on its earlier ruling in *Pretty*, in which the Court held that the right to respect for private life under Article 8 includes a right to "*avoid…an undignified and distressing end to…life*" [67]. In *Haas v Switzerland* (2011) 53 EHRR 33 the Court explicitly accepted that: "*an individual's right to decide by what means and at what point his or her life will end, provided he or she is capable of freely reaching a decision on this question and acting in consequence, is one of the aspects of the right to respect for private life within the meaning of Article 8 of the Convention."* [51]. This was reiterated in *Gross v Switzerland* (2014) 58 EHRR 7.

Article 2 of the ECHR imposes on the authorities a duty to protect vulnerable persons, even against actions by which they endanger their own lives and obliges the national authorities to prevent an individual from taking his or her own life if the decision has not been taken freely and

with full understanding of what is involved. Linked to that obligation, and to ensure that the obligation is given effect, is a requirement on states to establish a procedure capable of ensuring that a decision by an individual to end their life does indeed correspond to the free wish of that individual.

Since there is still no European-wide consensus on the voluntary ending of life, the Court applies a certain margin of appreciation in considering the detailed arrangements in contracting states governing both whether and the extent to which this is permitted and the legal and institutional regime surrounding assisted dying, albeit that since Article 2 is at issue, that margin of appreciation will always be limited: *Mortier* §§142-143, see also *Lambert v France* (2016) 62 EHRR 2 §148 (withdrawal of treatment). The Court's power of review will be exercised regarding the requirement that the State must take appropriate steps to safeguard the lives of those within its jurisdiction, which in the public-health sphere includes regulations requiring hospitals, whether private or public, to adopt appropriate measures for the protection of patients' lives: *ibid*. §140.

Where a possibility is available for individuals to seek assisted dying, there must be comprehensive and clear guidelines governing the right to obtain assistance, the absence of which will violate the right to personal autonomy under Article 8: *Gross* [69]. The requisite legal and institutional safeguards must be sufficiently robust to prevent abuse so as to ensure respect for the right to life and the right to personal autonomy and dignity. Crucially, those safeguards must ensure that the decision of the individual to seek assisted dying is free, informed, explicit and unambiguous: *Daniel Karsai* §§126-12.

The draft Law meets the above requirements, setting out detailed rules governing each and every stage of the process leading up to an assisted death. These rules precisely regulate the requirements for doctors to make the necessary decisions with precision at each stage of the process, ensuring at all stages that the individual is fully informed, has capacity and acts voluntarily so as to ensure protection for the right to life and prevent abuse. In this regard, the draft Law provides a multi-stage procedure and at each stage, provides for verification of the individual's capacity to take the decision and the voluntary nature of their decision. It is considered that this multi-step approach ensures that the right to life is property protected, as required by Article 2.

As regards whether the individual meets the health requirement of suffering from a terminal disease as defined in the draft Law, this is subject to an assessment by both the co-ordinating doctor and then an independent assessment doctor. In both cases, those doctors may seek a further opinion on the matter and are obliged to do so if they are unable to reach a decision without a further opinion. These repeated reviews ensure that the restrictions as laid down by the draft Law on when assisted dying will be available are effectively applied so as to protect the right to life, and in particular, the right to life of the vulnerable.

The patient's confidentiality is preserved in accordance with the requirements of Article 8: *Mortier* §§207-208.

In addition to appeal routes being available to individuals seeking assisted dying as well as those with an interest who believe that assisted dying would not be lawful, a review stage following death is provided for. These processes meet the procedural requirements of Articles 2 and 8 of the ECHR.

EXPLANATORY NOTE

This Law essentially provides for the assisted dying of someone who has a terminal illness, who is experiencing (or is expected to experience) unbearable suffering and who chooses to end their life with the help of a medical professional.

Part 1 (*Articles 1 and 2*) defines the terms used in the Law and the criteria for assisted dying.

Under *Article 1*, an assisted dying practitioner is 1 of the following professionals who is registered with the Assisted Dying Service (the "Service") for the role –

- an assessing doctor (a co-ordinating doctor, independent assessment doctor or second opinion doctor), who assesses an individual for eligibility for an assisted death;
- an administering practitioner, who arranges an individual's care planning and carries out their assisted death;
- a pharmacy professional, who prepares and dispenses approved drugs for an individual's assisted death;
- an extended team member, who is a health professional in a team that supports an individual's assisted dying process.

Under *Article 2*, an individual must meet criteria to be eligible for assisted dying. The criteria are –

- the health criteria;
- the capacity criterion;
- the decision criteria;
- the age criterion; and
- the residency criterion.

The first 3 are the "main criteria", and they must be met when the individual is assessed by an assessing doctor.

For the health criteria, the individual must –

- have a physical condition that is expected to cause their death within 6 months, or within 12 months if the condition is neurodegenerative;
- believe that they cannot, or would not be able to, bear the suffering that the condition causes, or is expected to cause, them; and
- if treatment could extend their life, or make their suffering from the condition bearable, believe that they would not be able to bear the suffering that the treatment is expected to cause them.

For the capacity criterion, the individual must have capacity to decide to end their life by assisted dying.

For the decision criteria –

- the individual must have decided to end their life by assisted dying; and
- the decision must be –
    - voluntary;

- clearly expressed;
- settled (by being maintained consistently since their first request for assisted dying); and
- informed.

To meet the age criterion, the individual must be aged 18 years or older when they make a first request for assisted dying.

The individual must meet, and continue to meet, the residency criterion at most steps in the assisted dying process. To meet the criterion, the individual must have been ordinarily resident in Jersey for the previous 12 months.

Part 2 has 2 Divisions.

Part 2, Division 1 (Articles 3 to 13), sets out the details of the 8 steps of the assisted dying process, including the basic requirements for how professionals assess an individual for eligibility. Each step must be completed for the next step to start. To decide something under a provision, a professional must decide whether they are satisfied of, or reasonably believe, the relevant matters (depending on the decision).

Article 3 covers step 1 of the assisted dying process (first request for assisted dying). An individual makes a first request for assisted dying by completing step 1. They complete step 1 if –

- they request to proceed to the next step, and their co-ordinating doctor decides that their request is voluntary and clearly expressed;
- the co-ordinating doctor decides that they meet the age and residency criteria; and
- they and the co-ordinating doctor together sign a form recording those matters.

Article 4 covers step 2 (first assessment of all criteria). At step 2, the individual's co-ordinating doctor must do a first assessment of them. In assessing them, the doctor must decide whether they meet the criteria for assisted dying. The individual completes step 2 if –

- the co-ordinating doctor signs a form recording that they meet the criteria;
- they request to proceed to the next step, and the co-ordinating doctor decides that their request is voluntary and clearly expressed; and
- they and the co-ordinating doctor together sign a form recording the request to proceed to the next step.

Article 5 covers step 3 (independent assessment of main and residency criteria). At step 3, the individual's independent assessment doctor must do an independent assessment of them. In assessing them, the doctor must independently decide whether they meet the main and residency criteria. The individual completes step 3 if –

- the independent assessment doctor signs a form recording that they meet the main and residency criteria;
- they request to proceed to the next step, and the co-ordinating doctor decides that their request is voluntary and clearly expressed; and
- they and the co-ordinating doctor together sign a form recording the request to proceed to the next step.

Article 6 covers step 4 (second request for assisted dying). An individual makes a second request for assisted dying by completing step 4. The individual completes step 4 if –

- they request to proceed to the next step, and their co-ordinating doctor decides that they have capacity and their request is voluntary, clearly expressed, settled and informed;
- they, the co-ordinating doctor and a qualifying witness together sign a form recording the request to proceed to the next step; and
- the co-ordinating doctor decides that they meet the residency criterion, and they and the co-ordinating doctor together sign a form recording that matter.

Article 7 covers step 5 (review and decision on request for assisted dying). At step 5, the individual's co-ordinating doctor must review, and decide whether to approve, their request for assisted dying. The doctor must approve the request if they decide that the individual has completed steps 1 to 4 in accordance with this Law. The co-ordinating doctor may also decide to override the minimum time frame for carrying out an assisted death if both the co-ordinating doctor and the independent assessment doctor (or another relevant doctor) decided at step 2 or 3, or later, that the individual's physical condition is expected to cause their death within 14 days. The individual completes step 5 if –

- their request for assisted dying is approved;
- they request to proceed to the next step, and the co-ordinating doctor decides that their request is voluntary and clearly expressed; and
- they and the co-ordinating doctor together sign a form recording the request to proceed to the next step.

Article 8 covers step 6 (care planning). An individual completes step 6 if –

- their administering practitioner decides that they meet the residency criterion;
- they request to proceed to the next step, and the administering practitioner decides that they have capacity and their request is voluntary and clearly expressed; and
- they and the administering practitioner together sign a form recording various matters, including –
    - that the practitioner has told the individual certain information; and
    - the individual's care plan.

The individual's care plan records their preferences for their assisted death.

Article 9 covers step 7 (final review and carrying out of assisted death). At step 7, the administering practitioner may carry out an individual's assisted death (by administration of approved drugs) if various requirements are met, including that –

- the minimum time frame for carrying out an assisted death (the 14th day after completion of step 1 and 2 working days after approval) is met or has been overridden;
- the administering practitioner decides that the individual meets the residency criterion;
- the administering practitioner is together with a qualifying witness;
- the administering practitioner decides, and signs a form recording, that it is appropriate to carry out the assisted death (because the individual has capacity and makes a voluntary final request or because they satisfied similar requirements at step 6 when waiving the requirement for future capacity); and
- there is no other practical reason for not carrying out the assisted death.

Articles 10 to 12 also cover step 7. *Article 10* specifies how the individual's assisted death is carried out. The administering practitioner must carry it out in compliance with the individual's care plan, so far as reasonably practicable. *Article 11* specifies when the administering practitioner must, or may, delay or stop the individual's assisted death. And *Article 12* requires the administering practitioner to dispose of approved drugs that are not used.

Article 13 covers step 8 (review after death). It sets out requirements so that the Review Panel can review each assisted death. It also requires a certifying doctor to certify the fact and cause of the individual's assisted death.

Part 2, Division 2 (Articles 14 to 35), sets out matters relating to the assisted dying process, including more details about how professionals assess an individual for eligibility.

Article 14 covers an individual's consent to the sharing of their information.

Article 15 lets an individual withdraw their request for assisted dying or pause their assisted dying process.

Article 16 provides for how a person may sign a form for an individual who is physically unable to sign it.

Article 17 sets out the requirements, at each step, for an individual to request to proceed to the next step (such as their doctor reasonably believing that their request is voluntary and clearly expressed).

Article 18 specifies which meetings relating to an individual must be held in Jersey or in person.

Article 19 requires professionals to disclose their interests that might, or might be seen to, conflict with a specific individual's interests in their assisted dying process.

Article 20 requires doctors involved in independent assessments to disclose their interests that might, or might be seen to, conflict with their independence in assessing an individual.

Articles 21 and 22 require an interests review officer to review the form disclosing a person's interests and to decide whether the person's involvement in the individual's process, or relationship with the individual's co-ordinating doctor, is a problem.

Article 23 requires an assessing doctor or the administering practitioner, at certain steps, to –

- decide on the extent to which the individual requires independent advocacy or communication support to properly receive and understand, and convey, information about their request for (or decision to end their life by) assisted dying; and
- try to arrange for the required independent advocacy or communication support to be provided.

Regulations are to provide for independent advocates and independent advocacy.

Article 24 lets an assessing doctor stop their assessment, so that criteria remain unassessed, if they are deciding whether an individual meets 2 or more of the criteria for assisted dying and they decide that 1 of the criteria is unmet.

Article 25 specifies how an assessing doctor must predict –

- for the health criteria, whether an individual's physical condition is expected to cause their death within a certain period, or the degree of suffering that a physical condition or its treatment is expected to cause an individual; or
- for the minimum time frame for carrying out an assisted death, whether an individual's physical condition is expected to cause their death within a certain period.

Article 26 specifies how an assessing doctor or administering practitioner must decide whether an individual has capacity for certain purposes under the Law.

Article 27 specifies how an assessing doctor or administering practitioner must decide whether an individual's decision or request is voluntary, clearly expressed or settled.

Article 28 specifies how an assessing doctor must decide whether an individual's decision or request is informed. *Article 29* sets out the specific information that the individual must be told under *Article 28*.

Article 30 applies an easier standard for an assessing doctor or administering practitioner to decide that the individual still satisfies the residency criterion after step 1.

Article 31 specifies which "relevant opinions" a professional must, or may, seek under the Law. The provisions for the steps themselves specify when a professional must, or may, seek the relevant opinions.

Articles 32 and 33 provide for second opinion assessments after an individual's first or independent assessment. A second opinion assessment is another way for the individual to meet the criteria at step 2 or 3.

Article 34 specifies how approved drugs are prescribed, prepared and dispensed.

Article 35 clarifies that an assisted dying practitioner or certifying doctor who is involved in an individual's assisted dying process may be replaced by another practitioner or doctor.

Part 3 has 5 Divisions.

Part 3, Division 1, spans *Articles 36 to 42*.

Articles 36 and 37 set out a specific right to refuse to participate in assisted dying. The right generally does not apply to an assisted dying practitioner, certifying doctor or care navigator (a non-clinical role of supporting an individual and helping the co-ordinating doctor).

Articles 38 and 39 protect an employee, partner or tenant from a detriment caused by their actual or potential –

- involvement in an assisted dying process, or in other activities, under the Law; or
- refusal to participate in assisted dying under *Article 36*.

Article 40 bans certain activities in safe access zones. Regulations are to specify the activities, safe access zones and any applicable duration for the bans.

Article 41 prohibits the disclosure of information –

- that allows a person to be identified as the individual in an assisted dying process or as someone involved in a particular individual's assisted dying process;
- about the carrying out of an individual's assisted death; or
- that allows approved drugs to be identified.

There are exceptions to the prohibition.

Article 42 specifies which decisions made under the Law may be appealed to the Royal Court and how they may be appealed. Only certain decisions can be appealed and only on certain grounds.

Part 3, Division 2, spans *Articles 43 to 53*.

Article 43 states that assisted dying, or an assisted death, is not suicide for the purposes of a law or contract. It protects people who perform functions under the Law in respect of an individual from –

- committing a criminal offence; and
- civil and disciplinary liability.

Articles 44 to 53 set out offences and penalties for committing the offences. The offences relate to –

- unlawfully administering approved drugs;
- coercing or dishonestly inducing a decision about assisted dying;
- giving false or misleading information or forging a document;
- purporting to act as an assisted dying practitioner, certifying doctor or care navigator;
- purporting to be an assisted dying practitioner, certifying doctor or care navigator;
- purporting to be the Service or providing assisted dying;
- promoting or advertising assisted dying;
- not telling the Service about significant registration matters;
- disclosing information about people or approved drugs;
- doing a banned activity in a safe access zone.

The penalty specified for an offence is the maximum penalty. If the penalty is a fine of level 3 on the standard scale, the maximum penalty is £10,000.

Part 3, Division 3, spans *Articles 54 to 76*. It covers the Assisted Dying Assurance and Delivery Committee (the "Committee") and its functions. The Minister for Health and Social Services (the "Minister") must establish and maintain the Committee. The Committee's main function is to supervise the Service's establishment and to continue to supervise the Service's provision of services. The Committee also –

- must approve the approved drugs that are used for assisted deaths;
- must arrange for the development and maintenance of a system that holds individuals' records (relating to their assisted dying process);
- must arrange for the development and maintenance of a register of assisted dying practitioners and certifying doctors (the "register");
- must arrange for the Service or another supplier to develop and publish –
    - general information about the assisted dying process, including the information set out in *Schedule 1*;
    - standards for services in relation to assisted dying, and procedures for investigating and resolving complaints about the services; and
    - requirements for retaining individuals' records and other information held by the Service;
    - operational guidance on certain matters;
    - general guidance on certain matters;
    - the competencies that are required to perform the role of an assisted dying practitioner or a certifying doctor;
- must arrange for the Service or another supplier to develop and provide –
    - certain training;
    - support for individuals and their connected people and for assisted dying practitioners, certifying doctors and care navigators;
- may investigate the practice of an assisted dying practitioner or a certifying doctor, or the performance of a care navigator, so far as it relates to assisted dying, in accordance with Regulations;

- must collect and analyse information about assisted dying;
- must report certain information to the Minister and the Care Commission each year;
- may request reviews from the Review Panel and must respond to reports of the Review Panel.

The Committee must not disclose information about the practice of an assisted dying practitioner or a certifying doctor, or the performance of a care navigator, that it receives from the Service, from its own investigations or otherwise. There are exceptions to the prohibition.

Part 3, Division 4, spans *Articles 77 to 89*. It covers the Service and its functions. The Minister must make every effort to establish and maintain the Service. The Service generally acts as required by the Committee. The Service must provide assisted dying by arranging for the assisted dying process to be carried out for individuals. The ability to promote or advertise assisted dying or the Service is limited. The Service must operate the system that holds individuals' records and the register. The Service must not disclose information on the register, or information it holds about the practice of an assisted dying practitioner or a certifying doctor or the performance of a care navigator. There are exceptions to the prohibition.

Part 3, Division 5, spans *Articles 90 to 95*. It covers the Assisted Dying Review Panel (the "Review Panel") and its functions.

The Minister must establish and maintain the Review Panel. The Review Panel must –

- review each individual's assisted death that is carried out;
- review an individual's assisted dying process that ended before their assisted death, if requested by the Committee;
- when reasonably practicable, analyse the reports from 2 or more of its reviews to decide whether to recommend –
    - any general changes or improvements in the assisted dying process; or
    - any potential investigation into, or proceedings about, a professional's practice or performance.

Part 4 spans *Articles 96 to 102*. It covers secondary legislation, forms and final matters.

Article 96 provides for the States Assembly to make Regulations under the Law.

Article 97 provides for the Minister to make Orders under the Law.

Article 98 provides for the Royal Court to make rules of court for appeals under the Law.

Article 99 imposes requirements for forms that are completed and signed under the Law.

Article 100 and Schedule 2 provide for the transition that occurs when the Law comes into force.

Article 101 and Schedule 3 make amendments to other legislation that are related to the Law or are consequential on it coming into force.

Article 102 names the Law and specifies when it comes into force. Many of the Law's provisions, including those about the actual process for approval and carrying out of assisted dying, come into force on a day to be specified by the States by Act. But some provisions come into force earlier (7 days after the Law is registered) to allow preparation for the provision of assisted dying.

Jersey

DRAFT ASSISTED DYING (JERSEY) LAW 202-

Contents

Article

Jersey

DRAFT ASSISTED DYING (JERSEY) LAW 202-

A LAW to provide for the assisted dying of someone who has a terminal illness, who is experiencing (or is expected to experience) unbearable suffering and who chooses to end their life with the help of a medical professional.

Adopted by the States	*[date to be inserted]*
Sanctioned by Order of His Majesty in Council	*[date to be inserted]*
Registered by the Royal Court	*[date to be inserted]*
Coming into force	*[date to be inserted]*

THE STATES, subject to the sanction of His Most Excellent Majesty in Council, have adopted the following Law –

PART 1

DEFINITIONS AND CRITERIA

1 Interpretation

In this Law –

"administering practitioner" means a doctor or nurse –

(a) whose main role is to act at step 6 (care planning) and step 7 (final review and carrying out of assisted death), including by –

(i) arranging care planning for an individual; and

(ii) carrying out the individual's assisted death;

(b) who also has a role at step 8 (review after death);

(c) who is registered with the Service for the role; and

(d) who was not the individual's independent assessment doctor (but may have been involved in their assisted dying process in other ways – for example, as their co-ordinating doctor);

"approved drugs" means the medicinal products or controlled drugs approved by the Committee under Article 58;

"assess" means, as an assessing doctor, to assess an individual for whether –

(a) they meet 1 or more criteria for assisted dying; or

(b) their physical condition is expected to cause their death within 14 days;

"assessing doctor" means –

(a) a co-ordinating doctor;

(b) an independent assessment doctor; or

(c) a second opinion doctor;

"assisted death" means a death that will or did result from assisted dying;

"assisted dying" means ending an individual's life in accordance with this Law;

"assisted dying practitioner" –

(a) means 1 of the following professionals who is registered with the Service for the role –

(i) an assessing doctor;

(ii) an administering practitioner;

(iii) a pharmacy professional; or

(iv) an extended team member; and

(b) for clarity, does not include a certifying doctor or care navigator;

"assisted dying process" means the following 8 steps relating to assisted dying –

(a) step 1: first request for assisted dying;

(b) step 2: first assessment (of all criteria);

(c) step 3: independent assessment (of main and residency criteria);

(d) step 4: second request for assisted dying;

(e) step 5: review and decision on request for assisted dying;

(f) step 6: care planning;

(g) step 7: final review and carrying out of assisted death;

(h) step 8: review after death;

"Care Commission" means the Health and Social Care Commission established by Article 35 of the Regulation of Care (Jersey) Law 2014;

"care home" means the place where a care home service, as defined in paragraph 4 of Schedule 1 of the Regulation of Care (Jersey) Law 2014, is provided;

"care navigator" means a person –

(a) whose role is non-clinical and is to –

(i) support an individual during the assisted dying process; and

(ii) help the co-ordinating doctor to co-ordinate the assisted dying process;

(b) who is employed by the Service in the role; and

(c) who has completed the initial training, and any continuing training at the intervals set by the Committee, for the role under this Law;

"care plan" means a care plan (which generally sets out the individual's preferences for their assisted death) –

(a) as recorded under Article 8(1)(b)(ii); or

(b) as amended under this Law;

"certifying doctor" means a doctor –

(a) whose main role is to act at step 8 (review after death), including by complying with Article 64(1) of the Marriage and Civil Status (Jersey) Law 2001 (by certifying an individual's assisted death and giving the certificate to the administering practitioner);

(b) who also has a role at step 6 (care planning);

(c) who is registered with the Service for the role; and

(d) who was not an assisted dying practitioner, or the care navigator, for the individual;

"close relative", of a person, means –

(a) their spouse or civil partner;

(b) another person (whether of the same or a different sex) with whom they live as partner in an enduring family relationship; or

(c) their child, parent, sister, brother, grandparent, grandchild, aunt, uncle, nephew, niece or first cousin (meaning a cousin with whom they share grandparents), including for a step or half relationship;

"co-ordinating doctor" means a doctor –

(a) whose main role is to act at step 1 (first request for assisted dying), step 2 (first assessment), step 4 (second request for assisted dying) and step 5 (review and decision on request for assisted dying), including by –

(i) co-ordinating an individual's assisted dying process;

(ii) first assessing the individual; and

(iii) deciding whether to approve or refuse the individual's request for assisted dying; and

(b) who also has a role at step 3 (independent assessment); and

(c) who is registered with the Service for the role;

"Committee" means the Assisted Dying Assurance and Delivery Committee established by the Minister under Article 54;

"communication support" means the following support for communication that is arranged under Article 23 –

(a) independent advocacy, so far as it supports communication; or

(b) other support for communication, such as support from an interpreter, a speech and language therapist, a connected person or any communication software or technology;

"connected person" means a person who has a personal relationship with an individual (such as a family member, friend, neighbour or colleague);

"criteria for assisted dying" has the meaning given in Article 2;

"doctor" means a person who is professionally registered as a doctor;

"employment" –

(a) has the meaning given in the Employment (Jersey) Law 2003; and

(b) includes prospective employment;

"end-of-life", for care or treatment, means palliative care or treatment that is provided to someone who is likely to die within 1 year;

"extended team member" means a person –

(a) who is a health professional;

(b) whose role is to be a member of a team that supports an individual's assisted dying process; and

(c) who is registered with the Service for the role;

"general guidance" means general guidance approved under Article 63;

"Health and Care Jersey" means the administration of the States (as defined in Article 1 of the Employment of States of Jersey Employees (Jersey) Law 2005) –

(a) that relates to health; and

(b) for which the Minister is assigned responsibility;

"health professional" means –

(a) a doctor;

(b) a nurse;

(c) a pharmacist or pharmacy technician;

(d) a dentist, optometrist or dispensing optician, meaning a person who is professionally registered as that; or

(e) an occupational therapist, physiotherapist, social worker or speech and language therapist, or a person in another registrable occupation under the Health Care (Registration) (Jersey) Law 1995, in each case meaning a person who is professionally registered as that;

"independent advocate" means an independent advocate appointed under Regulations made under Article 96(1)(a);

"independent advocacy" means the help (such as support and advocacy) given by an independent advocate to an individual, under Regulations made under Article 96(1)(a), in relation to a request for, or the process of, assisted dying;

"independent assessment doctor" means a doctor –

(a) whose main role is to act at step 3 (independent assessment), including by independently assessing an individual;

(b) who is registered with the Service for the role; and

(c) who is not an individual's co-ordinating doctor or second opinion doctor;

"individual" means an individual who requests, proposes or tries to request or is considering requesting assisted dying;

"individual's records", for an individual, means –

(a) their name, address and other personal details;

(b) the forms that are completed and signed (by them or another person) for their assisted dying process, including forms disclosing interests in relation to them; and

(c) everything that is recorded about them, and their assisted dying process, under this Law;

"interests review officer" means –

(a) the Medical Director (or their equivalent) in Health and Care Jersey; or

(b) a person appointed by the Medical Director;

"main criteria" means the following criteria for assisted dying –

(a) the health criteria;

(b) the capacity criterion;

(c) the decision criteria;

"Medical Officer of Health" means the person appointed under Article 10 of the Loi (1934) sur la Santé Publique;

"minimum time frame for carrying out an assisted death" has the meaning given in Article 9(1)(d)(i);

"Minister" means the Minister for Health and Social Services;

"nurse" means a person who is professionally registered as a nurse;

"operational guidance" means operational guidance approved under Article 62;

"Order" means an Order made under Article 97;

"pharmacist or pharmacy technician" means a person who is professionally registered as that;

"pharmacy professional" means a pharmacist or pharmacy technician –

(a) whose role is to prepare and dispense approved drugs for an individual's assisted death; and

(b) who is registered with the Service for the role;

"professionally registered", for each of the following professions, means both registered for the profession in Jersey, as specified in the relevant sub-paragraph, and registered for the equivalent profession in the United Kingdom –

(a) for a doctor, registered as a medical practitioner under the Medical Practitioners (Registration) (Jersey) Law 1960;

(b) for a pharmacist or pharmacy technician, registered as that under the Pharmacists and Pharmacy Technicians (Registration) (Jersey) Law 2010;

(c) for a dentist, registered as that under the Dentistry (Jersey) Law 2015;

(d) for an optometrist or a dispensing optician, registered as that under the Opticians (Registration) (Jersey) Law 1962;

(e) for a nurse, occupational therapist, physiotherapist, social worker or speech and language therapist, or a person in another registrable occupation under the Health Care (Registration) (Jersey) Law 1995, registered in that occupation under that Law;

"register" means the register described in Article 60 (which records people who perform a role as an assisted dying practitioner or certifying doctor);

"Review Panel" means the Assisted Dying Review Panel established by the Minister under Article 90;

"second opinion doctor" means a doctor –

(a) whose role is to act at step 2 (first assessment) or step 3 (independent assessment) if criteria are unmet after an assessment and the individual's request for a second opinion is accepted, including by doing a second opinion assessment;

(b) who is registered with the Service for the role; and

(c) who is not an individual's co-ordinating doctor or independent assessment doctor;

"Service" means the Assisted Dying Service established by the Minister under Article 77;

"States' employee" has the meaning given in Article 2 of the Employment of States of Jersey Employees (Jersey) Law 2005;

"step" means a step in the assisted dying process;

"working day" means a day other than –

(a) a Saturday, a Sunday, Good Friday or Christmas Day; or

(b) a public holiday or bank holiday under Article 2 of the Public Holidays and Bank Holidays (Jersey) Law 1951.

2 Criteria for assisted dying

(1) An individual is eligible for assisted dying if they meet the criteria under this Article ("criteria for assisted dying").

(2) The health criteria are that, when the individual is assessed –

(a) they have a physical condition that is expected to cause their death within the required period of –

(i) 6 months; or

(ii) 12 months if the condition is neurodegenerative;

(b) they believe that –

(i) they cannot bear the suffering that the condition causes them; or

(ii) they would not be able to bear the suffering that the condition is expected to cause them; and

(c) if treatment could extend their life beyond the required period, or make their suffering from the condition bearable, they believe that they would not be able to bear the suffering that the treatment is expected to cause them.

(3) The capacity criterion is that, when the individual is assessed, they have capacity to decide to end their life by assisted dying.

(4) The decision criteria are that, when the individual is assessed –

(a) they have decided to end their life by assisted dying; and

(b) the decision is –

(i) voluntary;

(ii) clearly expressed;

(iii) settled (by being maintained consistently since their first request for assisted dying); and

(iv) informed.

(5) The age criterion is that the individual is aged 18 years or older when they make a first request for assisted dying.

(6) The residency criterion is that the individual was ordinarily resident in Jersey for the 12 months immediately before the following –

(a) their first request for assisted dying, if they are at step 1;

(b) their assessment, if they are at step 2 or 3;

(c) their second request for assisted dying, if they are at step 4;

(d) the signing of the form (which includes the individual's care plan), if they are at step 6; or

(e) the carrying out of the individual's assisted death, if they are at step 7.

(7) In this Article –

"ordinarily resident in Jersey" includes the meaning given in Articles 2 and 3 of the Long-Term Care (Residency Conditions) (Jersey) Regulations 2013, as if they applied for the purposes of this Article;

"physical condition" means 1 or more diseases, illnesses, lesions, injuries, disorders or other conditions that –

(a) are physical; and

(b) for clarity, are not solely mental (such as disorders of anxiety, depression, eating, personality, post-traumatic stress and psychosis).

PART 2

ASSISTED DYING PROCESS AND RELATED MATTERS

DIVISION 1 – ASSISTED DYING PROCESS (STEPS 1 TO 8)

3 Step 1: first request for assisted dying

(1) An individual may start step 1 by –

(a) contacting the Service themselves; or

(b) being referred to the Service by someone else.

(2) An individual completes step 1 (and makes a first request for assisted dying) if the individual and the co-ordinating doctor, while meeting, complete and sign a form recording –

(a) the individual's request to proceed to the next step (see Article 17); and

(b) that the co-ordinating doctor is satisfied that the individual meets the age and residency criteria.

(3) Before acting under this Article, the doctor must tell the individual –

(a) that they may consent under Article 14 to their information being shared; and

(b) the advantages, and any disadvantages, of giving that consent.

(4) In deciding whether they are satisfied that the individual meets the age and residency criteria, the doctor may, or must (if necessary to decide), seek relevant opinions of others under Article 31.

(5) If the doctor cannot meet the requirements to complete and sign their part of the form –

(a) the doctor must, while meeting the individual, complete and sign a form –

(i) stating that they refuse the individual's attempt to request assisted dying; and

(ii) specifying the reasons for the refusal;

(b) the doctor must, while meeting the individual, tell the individual and give them written confirmation –

(i) that their attempt to request assisted dying is refused;

(ii) the reasons for the refusal; and

(iii) that they cannot have an assisted death unless overridden by an appeal to the Royal Court; and

(c) the assisted dying process ends unless overridden by an appeal to the Royal Court under Article 42.

(6) A co-ordinating doctor need not meet an individual who tries to start a new assisted dying process if –

(a) an earlier process was ended for any reason (such as refusal at step 1 or failure to meet criteria) and the doctor reasonably believes that the new process would also end for that reason; or

(b) an earlier process was ended by the individual withdrawing their request for assisted dying but the doctor reasonably believes that the earlier process would have ended for another reason anyway.

4 Step 2: first assessment (of all criteria)

(1) The co-ordinating doctor must do a first assessment of an individual if the individual has completed step 1 (by making a first request for assisted dying).

(2) For the first assessment, the co-ordinating doctor –

(a) must assess the individual at 1 or more meetings;

(b) must, while meeting the individual, decide whether they are satisfied that the individual meets the criteria for assisted dying (see Articles 23 to 28), and before or in deciding may, or must (if necessary to decide), seek relevant opinions of others under Article 31; and

(c) may, while meeting the individual, decide that they are satisfied that the individual's physical condition is expected to cause their death within 14 days (to override the minimum time frame for carrying out an assisted death), and before or in deciding may seek relevant opinions of others under Article 31.

(3) If the co-ordinating doctor decides that they are satisfied that the individual meets the criteria for assisted dying –

(a) the doctor must, while meeting the individual, complete and sign a form –

(i) stating that they are satisfied that the individual meets the criteria; and

(ii) if applicable, stating that they are satisfied that the individual's physical condition is expected to cause their death within 14 days; and

(b) the doctor must, while meeting the individual, tell the individual and give them written confirmation –

(i) that they meet the criteria;

(ii) that they may request to proceed to the next step; and

(iii) if applicable, that the minimum time frame for carrying out the assisted death may be overridden.

(4) The individual completes step 2 if –

(a) the form of the co-ordinating doctor states, or the forms of the co-ordinating doctor and second opinion doctor taken together state, that they are satisfied that the individual meets the criteria for assisted dying; and

(b) the co-ordinating doctor and the individual, while meeting, complete and sign a form recording the individual's request to proceed to the next step (see Article 17).

(5) If the co-ordinating doctor decides that they are not satisfied that the individual meets the criteria for assisted dying –

(a) the doctor must, while meeting the individual, complete and sign a form –

(i) stating that they are not satisfied that the individual meets the criteria; and

(ii) specifying which criteria are met, unmet or unassessed and the reasons for that;

(b) the doctor must, while meeting the individual, tell the individual and give them written confirmation –

(i) that they do not meet the criteria;

(ii) which criteria are unmet or unassessed; and

(iii) that they cannot have an assisted death unless overridden by a second opinion assessment of the main criteria or by an appeal to the Royal Court; and

(c) the assisted dying process ends unless overridden by a second opinion assessment of the main criteria under Article 33 or an appeal to the Royal Court under Article 42.

(6) The co-ordinating doctor may still make the decision under paragraph (2)(c) at any time after the first assessment (to override the minimum time frame for carrying out an assisted death) if –

(a) it is apparent that the individual's condition has deteriorated; and

(b) the individual has asked the doctor to decide, or decide again, about the matter.

5 Step 3: independent assessment (of main and residency criteria)

(1) The independent assessment doctor must do an independent assessment of an individual if the individual has completed step 2 (first assessment).

(2) For the independent assessment, the independent assessment doctor –

(a) must assess the individual –

(i) as to the main criteria at 1 or more meetings; and

(ii) as to the residency criterion;

(b) may review the assessing doctor's form from the first assessment or any second opinion assessment;

(c) may review the relevant opinions of others (if any) that were obtained under Article 31 by the assessing doctor in the first assessment or any second opinion assessment;

(d) may discuss the individual, or anything relating to whether they meet the main criteria –

(i) with the assessing doctor in the first assessment or any second opinion assessment; or

(ii) with any connected person or professional whose relevant opinion under Article 31 was sought by that assessing doctor, or with any other professional;

(e) must, while meeting the individual, independently decide whether they are satisfied that the individual meets the main criteria (see Articles 23 to 28), and before or in deciding may, or must (if necessary to decide), seek relevant opinions of others under Article 31;

(f) must decide whether they are satisfied that the individual meets the residency criterion (see Article 30); and

(g) may, while meeting the individual, independently decide that they are satisfied that the individual's physical condition is expected to cause their death within 14 days (to override the minimum time frame for carrying out an assisted death), and before or in deciding may seek relevant opinions of others under Article 31.

(3) If the independent assessment doctor decides that they are satisfied that the individual meets the main criteria and residency criterion –

(a) the independent assessment doctor must complete and sign, and give to the co-ordinating doctor, a form –

(i) stating that they are satisfied that the individual meets the main criteria and residency criterion; and

(ii) if applicable, stating that they are satisfied that the individual's physical condition is expected to cause their death within 14 days; and

(b) the co-ordinating doctor must, as soon as reasonably practicable after receiving the form and while meeting the individual, tell the individual and give them written confirmation –

(i) that they meet the criteria for assisted dying;

(ii) that they may request to proceed to the next step; and

(iii) if applicable, that the minimum time frame for carrying out the assisted death may be overridden.

(4) The individual completes step 3 if –

(a) the form of the independent assessment doctor or a second opinion doctor states, or those forms taken together state, that they are satisfied that the individual meets the main criteria and residency criterion; and

(b) the co-ordinating doctor and the individual, while meeting, complete and sign a form recording the individual's request to proceed to the next step (see Article 17).

(5) If the independent assessment doctor decides that that they are not satisfied that the individual meets the main criteria and residency criterion –

(a) the independent assessment doctor must complete and sign, and give to the co-ordinating doctor, a form –

(i) stating that they are not satisfied that the individual meets the main criteria and residency criterion; and

(ii) specifying which criteria are met, unmet or unassessed and the reasons for that;

(b) the co-ordinating doctor must, as soon as reasonably practicable after receiving the form and while meeting the individual, tell the individual and give them written confirmation –

(i) that they do not meet the criteria for assisted dying;

(ii) which criteria are unmet or unassessed; and

(iii) that they cannot have an assisted death unless overridden by a second opinion assessment of the main criteria or by an appeal to the Royal Court; and

(c) the assisted dying process ends unless overridden by a second opinion assessment of the main criteria under Article 33 or an appeal to the Royal Court under Article 42.

(6) The independent assessment doctor or, if they are not available, another doctor registered with the Service to assess individuals may still make the decision under paragraph (2)(f) at any time after the independent assessment (to override the minimum time frame for carrying out an assisted death) if –

(a) it is apparent that the individual's condition has deteriorated; and

(b) the individual has asked the doctor to decide, or decide again, about the matter.

6 Step 4: second request for assisted dying

(1) An individual completes step 4 (and makes a second request for assisted dying) if –

(a) they have completed step 3 (independent assessment); and

(b) they and the co-ordinating doctor complete and sign a form recording –

(i) the individual's request to proceed to the next step, while meeting together with a witness (see Article 17); and

(ii) that the co-ordinating doctor is satisfied that the individual meets the residency criterion (see Article 30).

(2) If the doctor cannot meet the requirements to complete and sign their part of the form –

(a) the doctor must, while meeting the individual, complete and sign a form –

(i) stating that they refuse the individual's request for assisted dying; and

(ii) specifying the reasons for the refusal;

(b) the doctor must, while meeting the individual, tell the individual and give them written confirmation –

(i) that their request for assisted dying is refused;

(ii) the reasons for the refusal; and

(iii) that they cannot have an assisted death unless overridden by an appeal to the Royal Court; and

(c) the assisted dying process ends unless overridden by an appeal to the Royal Court under Article 42.

7 Step 5: review and decision on request for assisted dying

(1) The co-ordinating doctor must review, and decide whether to approve, an individual's request for assisted dying if the individual has completed step 4 (by making a second request for assisted dying).

(2) The co-ordinating doctor must, while meeting the individual, decide to –

(a) approve the request if they are satisfied that the individual has completed steps 1 to 4 in accordance with this Law; and

(b) refuse the request otherwise.

(3) In making the decision, the co-ordinating doctor –

(a) must review the individual's records, and do anything else required, to confirm that each step (and form) has been completed in accordance with this Law;

(b) if any step has not been completed in accordance with this Law, must try to ensure that it is so completed by requiring all or part of the step to be done again (including by seeking any required relevant opinions of others under Article 31);

(c) may seek advice from any person, including advice about this Law; and

(d) may also decide to override the minimum time frame for carrying out an assisted death if the following have decided that they are satisfied that the individual's physical condition is expected to cause the individual's death within 14 days –

(i) the co-ordinating doctor under Article 4(2)(c) or (6); and

(ii) the independent assessment doctor or another doctor under Article 5(2)(g) or (6).

(4) If the co-ordinating doctor decides to approve the request –

(a) the co-ordinating doctor must, while meeting the individual, complete and sign a form –

(i) stating that they approve the individual's request for assisted dying; and

(ii) if applicable, stating that they are overriding the minimum time frame for carrying out an assisted death;

(b) where an override under sub-paragraph (a)(ii) is based on an independent assessment doctor's or another doctor's decision under Article 5(6) (after the independent assessment), that other doctor must state their decision in the form and sign the form;

(c) the co-ordinating doctor must, while meeting the individual, tell the individual and give them written confirmation –

(i) that their request for assisted dying is approved;

(ii) that they may request to proceed to the next step; and

(iii) if applicable, that the minimum time frame for carrying out the assisted death is overridden;

(d) the individual completes step 5 if the co-ordinating doctor and the individual then, while meeting, complete and sign a form recording the individual's request to proceed to the next step (see Article 17); and

(e) for clarity, the co-ordinating doctor's approval of the request does not expire.

(5) If the co-ordinating doctor decides to refuse the request –

(a) the doctor must, while meeting the individual, complete and sign a form –

(i) stating that they refuse the individual's request; and

(ii) specifying the reasons for the refusal;

(b) the doctor must, while meeting the individual, tell the individual and give them written confirmation –

(i) that their request for assisted dying is refused;

(ii) the reasons for the refusal; and

(iii) that they cannot have an assisted death unless overridden by an appeal to the Royal Court; and

(c) the assisted dying process ends unless overridden by an appeal to the Royal Court under Article 42.

8 Step 6: care planning

(1) An individual completes step 6 if –

(a) they have completed step 5 (review and decision on request for assisted dying); and

(b) they and the administering practitioner, while meeting, complete and sign a form recording –

(i) the practitioner's statement that they have told the individual the information required by paragraphs (2) and (3);

(ii) the individual's care plan as required by paragraph (4);

(iii) any option described in paragraph (2)(g) that the individual has chosen;

(iv) that the administering practitioner is satisfied that the individual meets the residency criterion (see Article 30);

(v) the individual's request to proceed to the next step (see Article 17); and

(vi) the arrangements for a certifying doctor to attend the individual within the period required by Article 64(2)(a) of the Marriage and Civil Status (Jersey) Law 2001, and while the individual had their condition, and to view the individual's body after death (so that the doctor will qualify under that provision).

(2) The required information is information about the following, as it relates to and is appropriate for the individual –

(a) general information about the approved drugs;

(b) the option of who administers approved drugs to the individual, whether the individual themselves or a practitioner;

(c) the options for how the approved drugs are administered, such as swallowing or injection;

(d) any risks of each option about –

(i) who administers the approved drugs; or

(ii) how the approved drugs are administered;

(e) the options for the place for the assisted death;

(f) the involvement of family members or friends in the carrying out of the assisted death and any risks for those people;

(g) the individual's choice to do any of the following, and the implications of each choice –

(i) to (at step 6) consent to the continued carrying out of the assisted death (at step 7);

(ii) to (at step 6) make their final request for assisted dying and waive the requirement for future capacity;

(iii) to decide in advance to refuse treatment (such as resuscitation).

(3) The required information is also –

(a) that the individual is expected to die if approved drugs are administered to them; and

(b) that the individual may withdraw their request for assisted dying (under Article 15) at any time before the approved drugs are administered.

(4) The individual's care plan must record –

(a) their preferences for their assisted death, including –

(i) when, and in which place, it will be done;

(ii) who will administer approved drugs to them, whether the individual themselves or a practitioner; and

(iii) how the approved drugs will be administered, such as swallowing or injection; and

(b) the administering practitioner's agreement (if any) to themselves administering approved drugs to the individual, for the purposes of an exception under Article 36(1).

(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).

(6) If paragraph (5) applies, the administering practitioner must, while meeting the individual –

(a) decide –

(i) whether the practitioner is satisfied that the individual has capacity to make a final request for assisted dying (see Article 26); and

(ii) if so, whether the practitioner reasonably believes that the final request is voluntary (see Article 27); and

(b) complete and sign a form –

(i) recording the details of their decision-making under sub-paragraph (a);

(ii) stating that they have decided on the matters under sub-paragraph (a);

(iii) specifying their decisions; and

(iv) if any decision is negative, specifying the reasons for the decision.

(7) The individual (at step 6) makes their final request for assisted dying and waives the requirement for future capacity only if the administering practitioner signs the form under paragraph (6)(b) specifying positive decisions on each matter under paragraph (6)(a).

(8) If a person who purports to have a special interest appeals against any matter relating to the individual under Article 42(3), the form must not be completed and signed under paragraph (1)(b) until the appeal has been finally determined or withdrawn.

(9) The individual and the administering practitioner may, at any time before the approved drugs are administered –

(a) amend the care plan recorded as part of the form described by paragraph (1)(b)(ii); and

(b) sign the amended form.

9 Step 7: final review and carrying out of assisted death

(1) The administering practitioner may carry out an individual's assisted death (by administration of approved drugs) if –

(a) the individual has completed step 6 (care planning);

(b) the certifying doctor has attended the individual as arranged under Article 8(1)(b)(vi);

(c) the individual is in Jersey at the place approved by the practitioner for the assisted death;

(d) in respect of time –

(i) the minimum time frame for carrying out an assisted death is met, meaning that it is at least the 14th day after the day on which the individual completed step 1, and at least 2 working days have passed after the day on which the co-ordinating doctor signed the form approving the request for assisted dying (at step 5); or

(ii) the co-ordinating doctor has decided to override that minimum time frame;

(e) the administering practitioner is satisfied that the individual meets the residency criterion (see Article 30);

(f) the administering practitioner is together in person with a witness who –

(i) is a doctor, a nurse or an assisted dying practitioner;

(ii) if applicable (because the witness agrees to do so), has completed and signed a form recording their agreement to witness the administering practitioner themselves administering approved drugs to the individual, for the purposes of Article 36(1); and

(iii) watches the preparation for, and the carrying out of, the approved drugs' administration; and

(g) the administering practitioner has signed the form under paragraph (2)(d) (about the individual's final request and capacity) stating their decision that it is appropriate to carry out the assisted death;

(h) there is no other practical reason for not carrying out the assisted death (for example, the individual is vomiting or has asked for a delay);

(i) where a person who purports to have a special interest has appealed against any matter relating to the individual under Article 42(3), the appeal has been finally determined or withdrawn;

(j) the approved drugs are administered as soon as reasonably practicable after the administering practitioner signs the form under paragraph (2)(d); and

(k) where paragraph (2)(c)(i)(B) applies, the individual does not show any refusal of, or resistance to, the approved drugs' administration.

(2) The practitioner must, while meeting the individual –

(a) decide whether they are satisfied that the individual has capacity to make a final request for assisted dying (see Article 26);

(b) if they are satisfied that the individual has that capacity and if the individual has made the final request at step 7, decide whether they reasonably believe that the final request is voluntary (see Article 27);

(c) decide that –

(i) it is appropriate to carry out the assisted death if –

(A) the practitioner is satisfied that the individual has that capacity and reasonably believes that the final request is voluntary; or

(B) the practitioner is not satisfied that the individual has that capacity but the individual has (at step 6) made their final request

for assisted dying and waived the requirement for future capacity; or

(ii) it is not appropriate to carry out the assisted death, otherwise; and

(d) complete and sign a form recording the details of their decision-making under sub-paragraphs (a) to (c) and stating the matters required by paragraph (3).

(3) In the form, the practitioner must state –

(a) whether they are satisfied that the individual has completed step 6 (care planning);

(b) that they have decided under paragraph (2) –

(i) that it is appropriate to carry out the assisted death, having properly considered the individual's care plan; or

(ii) that it is not appropriate to carry out the assisted death, giving the reasons why and specifying either that they have decided to delay the assisted death or that the assisted dying process has ended unless overridden by an appeal (see Article 11).

(4) The practitioner must not approve a place for an individual's assisted death unless –

(a) they are satisfied that the assisted death can be safely carried out there, having considered –

(i) any risks there that may make it unsuitable; and

(ii) the views of others who live there; and

(b) for a care home whose service is not provided by Health and Care Jersey, the provider or manager has agreed that the assisted death may be carried out there.

(5) In this Article, "provider or manager" means the provider or manager, under the Regulation of Care (Jersey) Law 2014, of the care home service provided at a care home.

10 Step 7: carrying out assisted death

(1) In carrying out an individual's assisted death, the administering practitioner –

(a) must do so in compliance with the individual's care plan, so far as reasonably practicable;

(b) must, if the individual administers the approved drugs themselves –

(i) give the approved drugs to the individual;

(ii) tell the individual and their helper (if any) how the approved drugs are taken; and

(iii) stay with and watch the individual while they take the approved drugs;

(c) must stay with or near the individual until they die; and

(d) may do 1 or more of the following if compliance with the care plan (so far as reasonably practicable) does not result in the individual's death and paragraph (2) applies –

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

(ii) administer the approved drugs themselves;

(iii) administer the approved drugs in a different way, such as swallowing or injection;

(iv) administer more approved drugs.

(2) This paragraph applies if –

(a) the individual has (at step 6) given consent to the continued carrying out of the assisted death (at step 7);

(b) the administering practitioner reasonably believes that the individual has capacity and the individual consents to the practitioner's proposed action; or

(c) the administering practitioner reasonably believes that the individual does not have capacity and the individual has (at step 6) made their final request for assisted dying and waived the requirement for future capacity.

(3) If the individual administers the approved drugs themselves, their family member or friend may help them to do so (for example, by helping them to raise the drugs to their mouth).

(4) A person need not act to preserve the individual's life once the approved drugs have been administered if the individual has not requested that.

11 Step 7: delaying or stopping assisted death

(1) The administering practitioner must decide to delay the assisted death if there is a practical reason for not carrying out the assisted death (see Article 9(1)(h)).

(2) The administering practitioner may decide to delay the assisted death if –

(a) they have decided (under Article 9(2)(c)) that it is not appropriate to carry out the assisted death; and

(b) in their opinion, the individual's capacity might be changing over time (because of their condition or its treatment, for example).

(3) If the assisted death is delayed, the practitioner must –

(a) so far as practicable, tell the individual that their assisted death is being delayed and the reasons why;

(b) decide on a new time for the assisted death, in consultation with the individual so far as practicable; and

(c) amend and sign the individual's care plan to record the new time for the assisted death.

(4) If the administering practitioner has decided that it is not appropriate to carry out the assisted death, and the assisted death is not delayed –

(a) the assisted dying process ends unless overridden by an appeal to the Royal Court under Article 42;

(b) the practitioner must, so far as practicable, tell the individual that they cannot have an assisted death (unless overridden by such an appeal) and the reasons why; and

(c) the practitioner must tell the co-ordinating doctor that the individual's assisted dying process has ended (unless the practitioner is that doctor).

12 Step 7: disposal of approved drugs

(1) The administering practitioner must dispose of any remaining approved drugs that were dispensed for an individual as soon as reasonably practicable after the individual's –

(a) assisted death is carried out; or

(b) assisted death is delayed or assisted dying process ends.

(2) The disposal must comply with any relevant legislation.

13 Step 8: review after death

(1) As soon as reasonably practicable after an assisted death –

(a) the administering practitioner must complete and sign a form specifying details about the assisted death; and

(b) the witness at step 7 must sign the form confirming that the form has been accurately completed.

(2) Within 2 working days after the day of the assisted death, the administering practitioner must –

(a) send a copy of the signed form to the Review Panel; and

(b) tell the certifying doctor about the assisted death and give them a copy of –

(i) the signed form; and

(ii) the form that the practitioner signed at step 7 (after their review).

(3) The certifying doctor must –

(a) view the individual's body after their death, for the purposes of Article 64(2)(a) of the Marriage and Civil Status (Jersey) Law 2001; and

(b) comply with Article 64(1) of that Law by certifying the fact and cause of the individual's assisted death and giving the certificate to the administering practitioner.

(4) The administering practitioner must comply with Article 62(1) of that Law by giving certain information and the certificate to the relevant registrar within 5 days after the individual's death.

DIVISION 2 – MATTERS RELATING TO ASSISTED DYING PROCESS

14 Consent to sharing of individual's information

(1) A person may share information about an individual with another person in accordance with the individual's consent given and recorded in a form signed by the individual.

(2) An assisted dying practitioner must make a record in an individual's records of each time that they ask them to give consent under paragraph (1).

15 Withdrawing request for assisted dying or pausing process

(1) An individual may, at any time before approved drugs are administered to them –

(a) withdraw their request for assisted dying;

(b) decide not to request to proceed to the next step of the assisted dying process; or

(c) pause the assisted dying process.

(2) The individual starts their withdrawal by –

(a) telling any assisted dying practitioner involved in their assisted dying process that they propose to withdraw their request; or

(b) telling the co-ordinating doctor at step 4 that they propose not to proceed to the next step.

(3) A practitioner under paragraph (2)(a) (other than the co-ordinating doctor) must, as soon as reasonably practicable, tell the co-ordinating doctor about the proposed withdrawal.

(4) In any case, the co-ordinating doctor must, as soon as reasonably practicable, discuss the proposal with the individual and confirm whether they want to withdraw.

(5) If the individual confirms that they want to withdraw, the assisted dying process ends and the co-ordinating doctor must –

(a) complete and sign a form recording that the individual has withdrawn their request for assisted dying;

(b) give written notice to the individual confirming that their request has been withdrawn and that their assisted dying process has ended; and

(c) tell any connected person or assisted dying practitioner involved in the assisted dying process about the withdrawal.

16 Another person may sign form for certain individuals

(1) An individual who is physically unable to sign a form under this Law may have a person sign it on their behalf.

(2) The person –

(a) must be aged 18 years or older;

(b) must not be –

(i) an assisted dying practitioner involved in the individual's assisted dying process; or

(ii) the witness to the form recording the individual's request to proceed from step 4 (second request for assisted dying) to the next step; and

(c) must be in person together with the individual when –

(i) the person is instructed by the individual to sign the form; and

(ii) the person signs the form.

17 Request to proceed to next step

(1) This Article applies if an individual at any of steps 1 to 6 requests to proceed to the next step.

(2) The co-ordinating doctor or administering practitioner must, while meeting the individual, decide whether the doctor or practitioner reasonably believes the following –

(a) at step 1, 2, 3 or 5 (see Article 27), that the individual's request is –

(i) voluntary; and

(ii) clearly expressed;

(b) at step 4 (see Articles 23 and 26 to 28) –

(i) that the individual has capacity to request assisted dying; and

(ii) that the individual's request is –

(A) voluntary;

(B) clearly expressed;

(C) settled (by being maintained consistently since their first request for assisted dying); and

(D) informed; or

(c) at step 6 (see Articles 23, 26 and 27) –

(i) that the individual has capacity to request assisted dying; and

(ii) that the individual's request is –

(A) voluntary; and

(B) clearly expressed.

(3) The doctor or practitioner's reasonable belief –

(a) must be based on their meetings with the individual; and

(b) may also be based on relevant opinions of others, which the doctor or practitioner may, or must (if necessary to form the belief), seek under Article 31.

(4) But if the individual has (at step 6) made their final request for assisted dying and waived the requirement for future capacity, the doctor is taken to have made a positive decision under paragraph (2)(c) (so that its requirements effectively do not apply).

(5) If the doctor's or practitioner's decision under paragraph (2) is positive, they and the individual may, at a meeting, complete and sign a form recording the individual's request to proceed to the next step.

(6) Otherwise, the doctor or practitioner must comply with paragraph (8).

(7) At step 4, the form recording the individual's request to proceed to the next step may be completed and signed only together with a witness who –

(a) is aged 18 years or older;

(b) is not the individual's close relative or an assisted dying practitioner involved in the individual's assisted dying process;

(c) is unlikely to benefit financially or in any significant way from the individual's death (for example, under the individual's will) and does not believe otherwise;

(d) states in the form that they know the individual well enough to believe that the individual's request appears to satisfy paragraph (2)(b)(ii) (but without requiring the witness to consider Articles 26 to 28); and

(e) also signs the form.

(8) If this paragraph applies, the doctor or practitioner must –

(a) at a meeting, tell the individual and confirm to the individual in writing –

(i) which relevant matters in paragraph (2) they have decided they do not reasonably believe; and

(ii) the reasons for their decision;

(b) if the individual asks them to reconsider and they think it is reasonable that reconsideration may change their decision, reconsider the decision and take into account any further relevant information given by the individual; and

(c) either –

(i) if their decision under paragraph (2) becomes positive, complete and sign a form under paragraph (5) recording the individual's request to proceed to the next step; or

(ii) otherwise, while meeting the individual, complete and sign a form stating, and tell the individual and give the individual written confirmation that, the individual cannot proceed to the next step.

18 Meetings in person or electronically

(1) This Article applies to a meeting held under this Law between –

(a) an individual and 1 or more assisted dying practitioners; or

(b) 2 or more assisted dying practitioners in relation to an individual.

(2) Each person must be in Jersey unless an Order requires or allows the person to be in another place.

(3) The meeting must be held in person (between people at the same place), not electronically, unless the exception applies.

(4) The exception is that –

(a) the meeting is held without a witness; and

(b) either –

(i) the meeting is part of the assessing doctor's first assessment, independent assessment or second opinion assessment and during the assessment at least 1 other meeting with the individual is held in person; or

(ii) an Order requires or allows the meeting to be held electronically.

19 Disclosure of professional's interests for conflict with individual's interests

(1) This Article requires certain persons to –

(a) complete and sign a form disclosing their interests (if any) that might, or might be seen to, conflict with a specific individual's interests in their assisted dying process; and

(b) give the form to the individual's co-ordinating doctor (unless they are that doctor).

(2) The persons specified in paragraph (3) must sign such a form if –

(a) they become, or are to become, involved in the individual's assisted dying process; or

(b) at any time before the individual's process ends, they become aware of a relevant change in their interests, in their relationship with the individual or in what they know about the individual.

(3) The persons are –

(a) an assisted dying practitioner;

(b) a professional whose relevant opinion is sought under Article 31;

(c) an independent advocate;

(d) a person who provides communication support but is not a connected person;

(e) a care navigator; and

(f) a certifying doctor.

(4) If the person's form discloses 1 or more interests, the co-ordinating doctor must give it to an interests review officer (even if it is that doctor's form).

20 Disclosure of doctor's interests for conflict in individual's independent assessment

(1) This Article requires certain doctors to complete and sign a form disclosing their interests (if any) that might, or might be seen to, conflict with their independence in assessing an individual.

(2) A doctor must sign such a form if –

(a) they are to do an independent assessment or a second opinion assessment in relation to an independent assessment; or

(b) at any time before the individual's process ends, they become aware of a relevant change in their relationship with the co-ordinating doctor before their completion of the assessment.

(3) The doctors are –

(a) an independent assessment doctor; and

(b) a second opinion doctor in relation to an independent assessment.

(4) If the doctor's form discloses 1 or more interests, they must give it to an interests review officer.

21 Review of professional's interests for conflict with individual's interests

(1) An interests review officer must –

(a) review each form that they receive from a person under Article 19 in relation to an individual; and

(b) decide whether the person's involvement in the individual's process is a problem.

(2) The person's involvement is a problem only if –

(a) they are the individual's close relative;

(b) they are not, or believe that they are not, unlikely to benefit financially or in any significant way from the individual's death (for example, under the individual's will); or

(c) the disclosed interests might, or might be seen to, conflict with the individual's interests in their assisted dying process to such an extent that, in the officer's opinion, the person should not be involved in the process.

(3) If the officer decides that the person's involvement in the individual's assisted dying process is a problem –

(a) the person must not be involved in the process; and

(b) where the person has already been involved in the process –

(i) a step that was completed only because of their involvement is treated as not completed;

(ii) the officer must tell the co-ordinating doctor about the effect of clause (i) (whether they are the original or a replacement co-ordinating doctor); and

(iii) the co-ordinating doctor must try to ensure that the step is completed by requiring all or part of the step to be done again.

22 Review of doctor's interests for conflict in individual's independent assessment

(1) An interests review officer must –

(a) review each form that they receive from a doctor under Article 20 in relation to an individual's independent assessment; and

(b) decide whether the doctor's relationship with the individual's co-ordinating doctor is a problem.

(2) The doctor's relationship is a problem only if, before or while doing the assessment –

(a) they are the co-ordinating doctor's close relative;

(b) they have a personal relationship (such as being a friend or neighbour), or a work or financial relationship, with the co-ordinating doctor that might, or might be seen to, conflict with their independence in assessing the individual to such an extent that, in the officer's opinion, the doctor should not do the assessment.

(3) If the officer decides that the doctor's relationship with the individual's co-ordinating doctor is a problem –

(a) the doctor must not do the assessment; and

(b) where the doctor has already done the assessment –

(i) a step that was completed only because of the assessment is treated as not completed;

(ii) the officer must tell the co-ordinating doctor about the effect of clause (i); and

(iii) the co-ordinating doctor must try to ensure that the step is completed by requiring all or part of the step to be done again.

23 Independent advocacy and communication support during assisted dying process

(1) The following must comply with this Article –

(a) an assessing doctor at step 2 or 3 in deciding whether they are satisfied that an individual meets any criteria for assisted dying, including in any second opinion assessment;

(b) an assessing doctor or administering practitioner at step 4 or 6 in deciding whether they reasonably believe that an individual has capacity to request assisted dying (to request to proceed to the next step); or

(c) an administering practitioner at step 6 or 7 in deciding whether they are satisfied that an individual has capacity to make the final request for assisted dying.

(2) Before deciding, the doctor or practitioner must –

(a) decide on the extent to which the individual requires independent advocacy or communication support to properly receive and understand, and convey, information about their request for (or decision to end their life by) assisted dying; and

(b) try to arrange for the required independent advocacy or communication support to be provided.

(3) In making the decision and arrangements about independent advocacy or communication support, the doctor or practitioner must have regard to –

(a) the operational guidance about independent advocacy, communication support and support for interpretation of languages; and

(b) the availability of the independent advocacy or communication support.

(4) In making the decision about independent advocacy or communication support, the doctor or practitioner may seek relevant opinions of others under Article 31.

(5) If a person provides independent advocacy or communication support during any process that results in someone else completing and signing a form, the person must –

(a) describe the independent advocacy or communication support that they provided in the form; and

(b) also sign the form.

24 Assessment until individual fails to meet criteria

If an assessing doctor is deciding whether they are satisfied that an individual meets 2 or more of the criteria for assisted dying, and they decide that 1 of the criteria is unmet, they may stop the assessment so that the other criteria are unassessed.

25 Individual's life expectancy, suffering and treatment

(1) An assessing doctor must comply with paragraph (2) –

(a) at step 2, 3 or 5 in predicting, for the health criteria –

(i) whether an individual's physical condition is expected to cause their death within a certain period; or

(ii) the degree of suffering that a physical condition or its treatment is expected to cause an individual; or

(b) at step 2 or 3 (or at any later time allowed by Article 4(6) or 5(6)) in predicting, for the minimum time frame for carrying out an assisted death, whether an individual's physical condition is expected to cause their death within a certain period.

(2) The doctor –

(a) must predict the matter reasonably and based on their medical knowledge and on their assessment of the individual; but

(b) may base their prediction on a relevant opinion that they obtained under Article 31, as allowed by Article 31(3).

(3) An assessing doctor, in deciding whether they are satisfied of Article 2(2)(b) or (c) (in relation to the individual's suffering under the health criteria) –

(a) must satisfy themselves only that the individual believes what they claim; and

(b) if they believe that the individual would be able to bear suffering, must ignore their own belief.

26 Individual's capacity to decide or request

(1) An assessing doctor or administering practitioner must comply with this Article –

(a) at step 2 or 3, to decide that they are satisfied (under Article 4 or 5) that an individual has capacity to decide to end their life by assisted dying, for the individual to meet the capacity criterion;

(b) at step 4 or 6 to form a reasonable belief (under Article 17) that an individual has capacity to request assisted dying, for the individual to request to proceed to the next step; or

(c) at step 6 or 7 to decide that they are satisfied (under Article 8(2)(a) or 9(2)(a)) that an individual has capacity to make a final request for assisted dying.

(2) The doctor or practitioner must be satisfied that the individual has capacity to do the following, even if the individual needs (or would need) communication support to do so –

(a) receive the information given to them under this Law about their decision or request;

(b) understand the information and the matters relevant to their decision or request (including the effect of their decision or request);

(c) retain the information for long enough to make their decision or request;

(d) use or weigh the information and matters in making their decision or request; and

(e) convey their decision or request (by any means).

(3) The doctor or practitioner must assume that the person has that capacity unless there is evidence that they do not, whether based on –

(a) meetings with, or assessments or examinations of, the individual; or

(b) relevant opinions of others obtained under Article 31.

27 Individual's decision or request voluntary, clearly expressed and settled

(1) This Article applies in relation to an individual's –

(a) decision to end their life by assisted dying, for the individual to meet the decision criteria; or

(b) request for assisted dying, for the individual to request to proceed to the next step or make a final request for assisted dying.

(2) An assessing doctor must comply with paragraph (3) –

(a) at step 1, 4, 5 or 6 to form a reasonable belief (under Article 17) that the individual's request is voluntary; or

(b) at step 2 or 3 –

(i) to decide that they are satisfied (under Article 4 or 5) that the individual's decision is voluntary; and

(ii) to form a reasonable belief (under Article 17) that the individual's request is voluntary.

(3) The doctor –

(a) must talk to the individual about –

(i) why they wish to end their life by assisted dying; and

(ii) whether anyone has asked, coerced or pressured them, or they have felt coerced or pressured, to request assisted dying; and

(b) may seek relevant opinions of others under Article 31.

(4) An assessing doctor must comply with paragraph (5) –

(a) at step 1, 5 or 6 to form a reasonable belief (under Article 17) that the individual's request is clearly expressed;

(b) at step 2 or 3 –

(i) to decide that they are satisfied (under Article 4 or 5) that the individual's decision is clearly expressed and settled; and

(ii) to form a reasonable belief (under Article 17) that the individual's request is clearly expressed; or

(c) at step 4 to form a reasonable belief (under Article 17) that the individual's request is clearly expressed and settled.

(5) The doctor –

(a) must talk to the individual about –

(i) why they wish to end their life by assisted dying;

(ii) how long they have had that wish; and

(iii) whether their wish is consistent or changing; and

(b) may seek relevant opinions of others under Article 31.

(6) An administering practitioner must comply with paragraph (7) at step 6 or 7 to form a reasonable belief (under Article 8(2)(a) or 9(2)(b)) that the individual's final request is voluntary.

(7) The practitioner –

(a) must talk to the individual about whether anyone has asked, coerced or pressured them, or they have felt coerced or pressured, to request assisted dying; and

(b) may seek relevant opinions of others under Article 31.

28 Individual's decision or request informed

(1) An assessing doctor must comply with this Article –

(a) at step 2 or 3 to decide that they are satisfied (under Article 4 or 5) that an individual's decision to end their life by assisted dying (when made or maintained) is informed, for the individual to meet the decision criteria; or

(b) at step 4 to form a reasonable belief (under Article 17) that an individual's request for assisted dying is informed, for the individual to request to proceed to the next step.

(2) The assessing doctor must do something allowed by the table to ensure that the individual has been told the specific information that is described in Article 29 –

Assessing doctor	Tell individual personally	Arrange a suitably qualified person to tell individual and to confirm they have done so	Confirm that another assessing doctor or suitably qualified person has told individual
Co-ordinating	Allowed	Allowed	
Independent	Allowed	Allowed	
Second opinion	Allowed	Allowed	Allowed

(3) The assessing doctor must do something allowed by the table to ensure that the individual has been told the general information that is described in Article 61(a)(i) and published by the Service –

Assessing doctor	Tell individual personally	Confirm that another assessing doctor has told individual
Co-ordinating	Allowed	
Independent		Allowed
Second opinion		Allowed

(4) The assessing doctor must be satisfied that the individual understood the specific information and the general information.

29 Specific information relating to individual

(1) This Article sets out the specific information that an individual must be told for the purposes of Article 28(2).

(2) The specific information is information about the following, as it relates to and is appropriate for the individual –

(a) the physical condition that is expected to cause their death;

(b) the expected course of the condition;

(c) the options for care and treatment that are available to them, and the likely outcomes, including options –

(i) that are end-of-life or otherwise palliative; or

(ii) that the person may have previously discounted or discontinued;

(d) the assessing doctor's belief that the individual would be able to bear the suffering that the condition or its treatment is expected to cause them but only if the individual believes that they would not be able to bear the suffering and the assessing doctor disagrees;

(e) the matters described in Article 8(2), other than Article 8(2)(a).

(3) The specific information is also –

(a) the matters described in Article 8(3);

(b) that the individual must request to proceed before taking each step toward assisted dying;

(c) that the individual should talk to their family members or friends about their request for assisted dying, unless the assessing doctor believes that it is not reasonable to do so after discussing the individual's circumstances with them; and

(d) that the individual should decide whether they want any other practitioners or carers to be informed of their request for assisted dying.

30 Individual's residency

(1) This Article applies to an assessing doctor or administering practitioner if –

(a) they are deciding whether they are satisfied that an individual meets the residency criterion at a step other than step 1; and

(b) there is no evidence that the individual does not meet the residency criterion.

(2) The doctor or practitioner may merely have the individual confirm that they continue to meet the residency criterion.

31 Relevant opinions of others

(1) This Article applies to an assessing doctor or administering practitioner acting under any of the following provisions (which state that they may or must seek relevant opinions of others before, or in, deciding about a matter) –

(a) Article 3(4) (step 1, first request for assisted dying);

(b) Article 4(2)(b) or (c) or 33(2)(e) (step 2, first assessment or second opinion assessment);

(c) Article 5(2)(e) or (g) or 33(2)(e) (step 3, independent assessment or second opinion assessment);

(d) Article 17(3)(b) (steps 1 to 6, request to proceed to next step);

(e) Article 23(4) (steps 2 to 4, 6 or 7, independent advocacy and communication support during assisted dying process);

(f) Article 26(3) (steps 2 to 4, 6 or 7, individual's capacity to decide or request);

(g) Article 27(3)(b), (5)(b) or (7)(b) (steps 1 to 7, individual's decision or request voluntary, clearly expressed and settled).

(2) The relevant opinions are –

(a) connected people's personal opinions that the doctor or practitioner thinks will help them to decide, or form their belief, about the matter; and

(b) professionals' professional opinions (even for professionals who are not assisted dying practitioners or extended team members) that –

(i) the doctor or practitioner thinks are based on the required experience or expertise and will allow them to decide, or form their belief, about the matter; and

(ii) are, or are not, based on the professionals' own examination of the individual.

(3) If a professional opinion is sought, the doctor or practitioner –

(a) must have regard to it; and

(b) may (but need not) agree with it and base any part of their decision or belief on it.

(4) Before seeking a professional opinion, the doctor or practitioner must –

(a) tell the professional that the opinion relates to a request for assisted dying; and

(b) suggest that the professional consider the law that applies in the location in which they give the opinion.

32 Second opinion assessment (of main criteria): request

(1) An individual may request a second opinion assessment if the assessing doctor's form from the first or independent assessment ("original assessment") specifies that any of the main criteria are unmet.

(2) The co-ordinating doctor must have the request reviewed by a doctor ("review doctor") who –

(a) is registered with the Service; and

(b) has not been involved in the individual's assisted dying process.

(3) The review doctor –

(a) must review the assessing doctor's form from the original assessment;

(b) may review the relevant opinions of others (if any) that were obtained under Article 31 by the assessing doctor in the original assessment;

(c) may, as required to decide on the request –

(i) discuss with the assessing doctor their reasons for not being satisfied of the unmet main criteria;

(ii) discuss with the individual their reasons for believing that they meet the unmet main criteria; and

(iii) discuss the request with any connected person or professional whose relevant opinion was obtained under Article 31 by the assessing doctor, or with any other professional; and

(d) must –

(i) accept the request if they consider it reasonable to think that the results of the original and second opinion assessments may differ; or

(ii) refuse the request otherwise.

(4) If the review doctor refuses the request –

(a) they must tell the co-ordinating doctor –

(i) that they have refused the request; and

(ii) the reasons for the refusal; and

(b) the co-ordinating doctor must, as soon as reasonably practicable after that and while meeting the individual, tell the individual and give them written confirmation –

(i) that their request for a second opinion assessment is refused, and the reasons for the refusal; and

(ii) that they still do not meet the criteria and cannot have an assisted death unless overridden by an appeal to the Royal Court.

33 Second opinion assessment (of main criteria)

(1) A second opinion doctor (who might be the review doctor) must do a second opinion assessment of an individual if the review doctor accepts the individual's request for a second opinion assessment under Article 32.

(2) For the second opinion assessment, the second opinion doctor –

(a) must review the assessing doctor's form from the original assessment;

(b) must review the relevant opinions of others referred to in Article 32(3)(b);

(c) may discuss anything referred to in Article 32(3)(c);

(d) may themselves assess the individual at 1 or more meetings;

(e) must, while meeting the individual, decide whether they are satisfied that the individual meets the unmet main criteria and the unassessed main criteria, if any (the "remaining main criteria", and see Articles 23 and 25 to 28), and before or in deciding may seek relevant opinions of others under Article 31;

(f) must, while meeting the individual, complete and sign a form –

(i) stating that they are satisfied that the individual meets the remaining main criteria; or

(ii) stating that they are not satisfied that the individual meets the remaining main criteria, and specifying which criteria are met, unmet or unassessed and the reasons for that; and

(g) must give the form to the co-ordinating doctor.

(3) But the second opinion doctor must not state that they are satisfied that the individual meets any remaining main criteria unless it is based on their own assessment under paragraph (2)(d).

(4) The co-ordinating doctor must, as soon as reasonably practicable after receiving the form and while meeting the individual, tell the individual and give them written confirmation –

(a) that they meet the criteria for assisted dying and may request to proceed to the next step; or

(b) the following –

(i) that they still do not meet the criteria for assisted dying;

(ii) which criteria are unmet or unassessed; and

(iii) that they cannot have an assisted death unless overridden by an appeal to the Royal Court.

34 Prescribing, preparing and dispensing approved drugs

(1) Approved drugs may, for the purposes of an individual's assisted death –

(a) be prescribed only by a prescriber;

(b) be prepared and dispensed only by a pharmacy professional at the pharmaceutical department of a hospital provided by Health and Care Jersey; and

(c) be dispensed only to the prescriber or to another person who could be a prescriber but did not prescribe the drugs.

(2) In deciding on which approved drugs to prescribe for the individual's assisted death, the prescriber may –

(a) examine the individual at 1 or more meetings;

(b) consider the individual's records and other medical records; or

(c) consult a pharmacy professional.

(3) When the approved drugs are dispensed by the pharmacy professional, that pharmacy professional and the prescriber must complete and sign a form specifying the names of the drugs.

(4) In this Article, "prescriber" means 1 of the following people who is a doctor or is registered as any type of independent prescriber under the Health Care (Registration) (Jersey) Law 1995 –

(a) the individual's administering practitioner; or

(b) another assisted dying practitioner who is acting for the individual's administering practitioner.

35 Change of practitioners

(1) An assisted dying practitioner or a certifying doctor who is involved in an individual's assisted dying process may be replaced by another practitioner or doctor at any time.

(2) The practitioner or doctor who is being replaced must tell the individual about the change as soon as reasonably practicable.

PART 3

RIGHT TO REFUSE, PROTECTIONS, APPEALS, OFFENCES, COMMITTEE, SERVICE AND REVIEW PANEL

DIVISION 1 – RIGHT TO REFUSE, PROTECTIONS, SAFE ACCESS ZONES, DISCLOSURE OF INFORMATION AND APPEALS

36 Right to refuse to participate

(1) A person acting in a specified capacity may, on any grounds, refuse the specified participation in assisted dying unless an exception applies, as follows –

Person's capacity	Participation in assisted dying (that may be refused)	Exception (where right to refuse does not apply)
Anything not covered in another row	Any participation	–
Assisted dying practitioner (other than administering practitioner)	–	–
Certifying doctor	–	–
Care navigator	–	–

Person's capacity	Participation in assisted dying (that may be refused)	Exception (where right to refuse does not apply)
Administering practitioner	Administering approved drugs (themselves) to an individual	(a) They previously agreed to do it in the individual's care plan or (b) Doing it is required to deal with a medical complication after the individual administers approved drugs to themselves, and it is allowed by Article 10(1)(d)
Witness at step 7	Witnessing the administering practitioner (themselves) administering approved drugs to an individual	(a) They previously agreed to do it in a form signed at step 7 or (b) Doing it is required as part of the administering practitioner dealing with a medical complication as described above

(2) The right to refuse overrides any obligation under another Article of this Law or under a contract (of employment or otherwise).

(3) If a health professional refuses to participate as described in Article 37(1)(a)(i) (by not giving information that a person asks for), they must tell the person –

(a) that they are exercising the right to refuse under this Law;

(b) that the Service might be able to help the person; and

(c) how the person may find the Service's contact details.

(4) As examples of the effect of the table in paragraph (1) –

(a) under its first operative row, a person who is not acting in a capacity specified in another row may refuse any participation in assisted dying;

(b) under its third operative row, the right to refuse participation in assisted dying does not apply to anything done by a person who is acting in the capacity of a certifying doctor.

37 Meaning of participation in assisted dying

(1) Some activities that are participation in assisted dying (and so may be refused under Article 36(1)) are –

(a) giving information about assisted dying to anyone if –

(i) they have asked for it; or

(ii) they are being given information about how their condition might be treated;

(b) acting in the role of an assisted dying practitioner, a certifying doctor or a care navigator (if not already in that role);

(c) giving relevant opinions, including examining an individual for the purposes of a professional opinion, under Article 31;

(d) providing independent advocacy or communication support;

(e) preparing, or being there during the preparation of, any equipment used to administer approved drugs to an individual;

(f) administering, or being there during the administration of, approved drugs to an individual; and

(g) providing a care home whose service is not provided by Health and Care Jersey as the place for an assisted death, despite paragraph (2).

(2) Some activities that are not participation in assisted dying (and so are not covered by the right to refuse in Article 36(1)) are –

(a) providing an individual with a service that would be provided to a person who had not requested, or died from, assisted dying (whether or not the service is clinical or somehow relates to assisted dying), such as –

(i) providing them with an adult day care service, a care home service or a home care service (as described in Schedule 1 of the Regulation of Care (Jersey) Law 2014);

(ii) giving them physiotherapy;

(iii) driving them somewhere;

(iv) reserving an appointment time for them;

(v) giving any existing information (including medical information) about them to someone;

(vi) cleaning a room after their death; or

(vii) dealing with their body after their death;

(b) providing an individual with a clinical service that is not directly related to assisted dying, such as providing medical or nursing care for cancer; and

(c) providing management, supervisory, administrative or other services relating to the general provision of assisted dying, such as –

(i) acting as a responsible officer (under the Medical Practitioners (Registration) (Responsible Officers) (Jersey) Order 2014) for an assisted dying practitioner;

(ii) acting in the role of a member of the Committee or the Review Panel;

(iii) managing or supervising, or financially planning for, the Service;

(iv) collecting or analysing statistical information about the Service; or

(v) cleaning the Service's offices.

38 Employment and partnership protection (for involvement or non-participation)

(1) An employer must ensure that there is no employment detriment to their employee as a result of the employee's actual or potential –

(a) involvement in an assisted dying process, or in other activities, under this Law (whether as a professional, an individual or otherwise); or

(b) refusal to participate in assisted dying under Article 36.

(2) There is an employment detriment to an employee if –

(a) the employer decides not to employ them or to end their employment; or

(b) they are treated less favourably in that employment.

(3) A partner must ensure that there is no partnership detriment to another partner as a result of the other partner's actual or potential –

(a) involvement in an assisted dying process, or in other activities, under this Law (whether as a professional, an individual or otherwise); or

(b) refusal to participate in assisted dying under Article 36.

(4) There is a partnership detriment to a partner if –

(a) they are not invited to become a partner in the partnership;

(b) they are offered less favourable terms or conditions in being invited to become a partner in the partnership;

(c) their access to a benefit arising from being a partner in the partnership is denied or limited;

(d) they are expelled from the partnership; or

(e) they are otherwise treated less favourably, or subjected to any other detriment, in the partnership.

(5) In this Article, "partnership" –

(a) means a partnership described in Article 12(4) of the Discrimination (Jersey) Law 2013; and

(b) includes prospective partnership.

39 Residential tenancy protection (for involvement or non-participation)

(1) A landlord must ensure that there is no residential tenancy detriment to their tenant as a result of the tenant's actual or potential –

(a) involvement in an assisted dying process, or in other activities, under this Law (whether as a professional, an individual or otherwise); or

(b) refusal to participate in assisted dying under Article 36.

(2) There is residential tenancy detriment to a tenant if –

(a) the landlord decides not to grant them a residential tenancy or to end their residential tenancy; or

(b) the landlord or the relevant agreement prevents them from having an assisted death in the place they occupy under the residential tenancy.

(3) In this Article, "residential tenancy" –

(a) has the meaning given in Article 1 of the Residential Tenancy (Jersey) Law 2011; and

(b) includes a prospective residential tenancy.

40 Certain activities banned in safe access zones

A person must not do anything specified by Regulations in a safe access zone defined by Regulations during the period specified by Regulations.

41 Disclosure of information about people or approved drugs

(1) A person must not disclose any information –

(a) that allows a person to be identified as –

(i) the individual in an assisted dying process; or

(ii) someone involved in a particular individual's assisted dying process;

(b) about the carrying out of an individual's assisted death; or

(c) that allows approved drugs to be identified.

(2) But the person may disclose the information –

(a) if it is already available to the public;

(b) with the written consent of each person to whom the information relates or the executor or administrator of their estate, or under Article 14 (consent to sharing of individual's information);

(c) if required to protect someone's safety or well-being by ensuring that this Law is complied with;

(d) in accordance with another enactment or a court order;

(e) so that a function or an obligation can be performed under this Law;

(f) for the purposes of the enforcement of an enactment or the investigation or prosecution of an offence (in Jersey or elsewhere);

(g) for the purposes of the investigation of, or disciplinary proceedings about –

(i) a health professional's practice by their employer or a body that regulates their profession (in Jersey or elsewhere); or

(ii) a care navigator's performance by their employer; or

(h) if the information identifies the approved drugs and the administering practitioner tells the individual the information, at the individual's request, at step 6 or 7.

(3) The ban on disclosure in paragraph (1)(a)(i) and (b) do not apply to the individual or a connected person of the individual.

42 Appeals to Court against decisions

(1) A person may appeal against a decision made under this Law only –

(a) if they are a person specified in paragraph (2) or (3) appealing against a decision specified in that paragraph;

(b) on the following grounds –

(i) in respect of the health criteria, that the decision was irrational or was not made in accordance with this Law; or

(ii) in respect of anything else, that the decision was unreasonable or was not made in accordance with this Law;

(c) to the Inferior Number of the Royal Court; and

(d) within 28 days after the later of –

(i) the day on which the decision is made and recorded in the relevant form;

(ii) the day on which the individual is given written notice of the decision.

(2) An individual may appeal against a negative decision on any of the following matters –

(a) whether the individual meets 1 or more of the criteria for assisted dying;

(b) whether a doctor or practitioner reasonably believes relevant matters under Article 17(2) for the individual's request to proceed to the next step;

(c) whether the individual's request for assisted dying is approved under Article 7 (at step 5) but only so far as the decision relates to a matter covered by sub-paragraph (a) or (b);

(d) whether the individual's final request for assisted dying meets the requirements in Article 8(6)(a) or 9(2)(a) and (b) (at step 6 or 7, relating to the individual's capacity and whether the request is voluntary);

(e) whether it is appropriate to carry out the individual's assisted death, as decided under Article 9(2)(c) (at step 7).

(3) A person with a special interest may appeal against a positive decision on any of the following matters –

(a) whether the individual's request for assisted dying is approved under Article 7 (at step 5) but only so far as the decision relates to a matter covered by paragraph (2)(a) or (b) of this Article;

(b) whether the co-ordinating doctor reasonably believes the matters under Article 17(2)(a) for the individual's request to proceed from step 5 to 6.

(4) The Royal Court must determine the appeal as quickly as reasonably practicable and, in doing so, may –

(a) affirm the decision; or

(b) cancel the decision and –

(i) decide the matter itself; or

(ii) require the decision-maker or another person to reconsider the matter and make a new decision.

(5) There is no further right of appeal.

(6) An appeal is treated as being withdrawn if the individual to whom it relates dies.

(7) In this Article, "person with a special interest" means a person who the Court is satisfied has a special interest in a particular individual's care and treatment (such as certain connected people or professionals involved in the individual's assisted dying process).

DIVISION 2 – PROTECTION AND OFFENCES

43 Assisted dying is protected

(1) Assisted dying, or an assisted death, is not suicide for the purposes of a law or contract.

(2) Paragraph (3) applies to a person who –

(a) performs a function in respect of an individual;

(b) is authorised by this Law to perform the function; and

(c) performs the function –

(i) in good faith;

(ii) in a way that they reasonably believe is in accordance with this Law; and

(iii) reasonably believing that the individual has requested assisted dying.

(3) The person –

(a) does not commit an offence by performing the function; and

(b) if they also perform the function with reasonable care and skill, cannot be held liable in civil court or disciplinary proceedings because they performed the function.

(4) This Article overrides any other law.

44 Offence to unlawfully administer approved drugs

(1) A person commits an offence if –

(a) they administer, or assist in administering, approved drugs to another person; and

(b) they do so –

(i) intending to end the other person's life; and

(ii) knowing that, or being reckless as to whether, it is not in accordance with this Law.

(2) The person is liable to imprisonment for life.

45 Offence to coerce or dishonestly induce decision

(1) A person commits an offence if they coerce, or dishonestly induce, another person to –

(a) request assisted dying;

(b) decide to end their life by assisted dying or request assisted dying, including to request to proceed to the next step of the assisted dying process; or

(c) withdraw their request for assisted dying.

(2) The person is liable to imprisonment for 14 years.

46 Offence to give false or misleading information or forge document

(1) A person commits an offence if –

(a) they complete or give a form or other document purportedly under this Law; and

(b) they –

(i) intentionally or recklessly state or specify something material that is false or misleading in the form or document; or

(ii) forge the form or document with intent to deceive.

(2) The person is liable to imprisonment for 5 years.

47 Offence to purport to act as assisted dying practitioner, certifying doctor or care navigator

(1) A person commits an offence if –

(a) they intentionally purport to act as an assisted dying practitioner, in a particular role, or as a certifying doctor;

(b) they are not registered with the Service for the role or their registration for the role is suspended; and

(c) they know that, or are reckless as to whether, sub-paragraph (b) applies.

(2) A person commits an offence if –

(a) they intentionally purport to act as a care navigator;

(b) they are not employed by the Service in that role or have not completed the initial training, and any continuing training at the intervals set by the Committee, for the role under this Law; and

(c) they know that, or are reckless as to whether, sub-paragraph (b) applies.

(3) In either case, the person is liable to imprisonment for 14 years.

48 Offence to purport to be assisted dying practitioner, certifying doctor or care navigator

(1) A person ("person X") commits an offence if –

(a) they intentionally –

(i) purport to be an assisted dying practitioner, as a general role or in a particular role, or a certifying doctor; or

(ii) cause or allow another person to purport that they (person X) are in such a role;

(b) they –

(i) are not registered with the Service for the role; or

(ii) have had their registration for the role suspended; and

(c) they know that, or are reckless as to whether, sub-paragraph (b) applies.

(2) A person ("person Y") commits an offence if –

(a) they intentionally –

(i) purport to be a care navigator; or

(ii) cause or allow another person to purport that they (person Y) are in such a role;

(b) they –

(i) are not employed by the Service in the role; or

(ii) have not completed the initial training, and any continuing training at the intervals set by the Committee, for the role under this Law; and

(c) they know that, or are reckless as to whether, sub-paragraph (b) applies.

(3) In either case, the person is liable to imprisonment for 7 years.

49 Offence to purport to be Service or to provide assisted dying

(1) A person commits an offence if –

(a) they intentionally –

(i) purport that something is the Service; or

(ii) cause or allow another person to purport that something is the Service; and

(b) they know that it is not the Service.

(2) A person commits an offence if they provide, or purport to provide, assisted dying in breach of Article 78(2).

(3) In either case, the person is liable to imprisonment for 7 years.

50 Offence to promote or advertise assisted dying

(1) A person commits an offence if they promote or advertise assisted dying or the Service –

(a) by intentionally giving information that breaches Article 78(3)(a); or

(b) with an intention that breaches Article 78(3)(b).

(2) The person is liable to imprisonment for 14 years.

51 Offence to not tell Service about significant registration matters

(1) An assisted dying practitioner or a certifying doctor commits an offence if they do not tell the Service something as required by Article 84(1) and (3).

(2) The person is liable to a fine of level 3 on the standard scale.

52 Offence to disclose information about people or approved drugs

(1) A person commits an offence if –

(a) they intentionally or recklessly disclose information in breach of Article 41(1); and

(b) the disclosure is not allowed or excepted by Article 41(2) or (3).

(2) The person is liable to a fine of level 3 on the standard scale.

53 Offence to do banned activity in safe access zone

(1) A person commits an offence if they do something in a safe access zone, as specified by Regulations, in breach of Article 40.

(2) The person is liable to a fine of level 3 on the standard scale.

DIVISION 3 – COMMITTEE AND ITS FUNCTIONS

54 Committee established and members appointed

(1) The Minister must establish and maintain an Assisted Dying Assurance and Delivery Committee by appointing, and having the chair appoint, the required members.

(2) There must be no fewer than 7, and no more than 15, members of the committee.

(3) Of those members –

(a) 1 must be appointed by the Minister as the chair; and

(b) each of the rest must be appointed –

(i) by the Minister as a regular member; or

(ii) by the chair as a professional lead member.

(4) The Minister may appoint a person as the chair only if the Minister –

(a) first consults the Jersey Appointments Commission and considers its recommendations;

(b) is satisfied that the person is independent and –

(i) is not a paid employee of, and does not have a governance or management role for, a service that provides end-of-life or other palliative care in Jersey; and

(ii) is not directly affiliated with a group that campaigns for or against assisted dying in Jersey or its equivalent elsewhere; and

(c) is satisfied that the person has significant experience in supervising and assuring the provision of health and care services to patients.

(5) The Minister may appoint a person as a regular member only if –

(a) the Minister is satisfied that the person is 1 or more of the following –

(i) a representative of a service that provides end-of-life or other palliative care in Jersey and is not a service of Health and Care Jersey;

(ii) a person who has significant experience in supervising and assuring the provision of health and care services to patients and who is not an employee of Health and Care Jersey;

(iii) a person who is a representative of patients and who has experienced end-of-life or other palliative care in Jersey themselves or as provided to a family member or friend;

(iv) an expert in medical ethics;

(v) a person who has experience that the Minister considers to be relevant to supervising the Service and assuring its provision of assisted dying; and

(b) where the chair has been appointed, the Minister first consults the chair; and

(c) where the Minister considers it appropriate, the Minister first consults the Jersey Appointments Commission and considers its recommendations.

(6) The chair may appoint a person as a professional lead member only if the chair is satisfied that the person is a senior professional in Health and Care Jersey who has responsibility for other professionals and expertise in governance or professional practice and standards, such as the following (or their equivalents) –

(a) the Chief Officer;

(b) the Chief Nurse;

(c) the Medical Director.

(7) In this Article, "Jersey Appointments Commission" means the Commission established by Article 17 of the Employment of States of Jersey Employees (Jersey) Law 2005.

55 Terms of reference

(1) The Minister –

(a) must arrange for the Committee to develop, and may arrange for the Committee to amend, the Committee's terms of reference that set out its procedures for performing its functions and obligations, such as –

(i) its schedule for meetings;

(ii) whether it must hold any meetings in public;

(iii) how it votes and makes decisions; and

(iv) how it resolves a conflict of interest; and

(b) may approve the terms of reference, giving effect to them.

(2) Before approving the terms of reference, the Minister must consult the following bodies or people (or their equivalents) –

(a) the Committee;

(b) the Care Commission;

(c) the Chief Officer of Health and Care Jersey;

(d) the chair of the Advisory Board of Health and Care Jersey (if there is such a Board); and

(e) anyone else who the Minister thinks it is appropriate to consult.

56 Remuneration of members and payment of expenses

(1) The chair and the regular members of the Committee must be –

(a) paid the remuneration (if any) that is set by, or calculated in accordance with, a decision of the Minister; and

(b) repaid for the reasonable expenses that they claim.

(2) The annual income of the States of Jersey must be used to –

(a) make those payments; and

(b) pay the expenses for the administration of the Committee.

57 Functions and obligations

(1) The Committee's –

(a) main function is to supervise the Service's establishment and to continue to supervise the Service's provision of services, and includes any related function that is directed by the Minister; and

(b) other functions and obligations are as set out in this Law.

(2) The Committee must follow the procedures in its terms of reference when performing its functions and obligations.

(3) The Committee must –

(a) ensure that the Service operates in compliance with this Law and the Regulation of Care (Jersey) Law 2014; and

(b) ensure that the Service has regard to the operational guidance in its operation.

58 Approval of drugs

(1) The Committee must approve any of the following (including any combination of them) for the purpose of causing the assisted death of individuals –

(a) a medicinal product, as defined in Article 2 of the Medicines (Jersey) Law 1995;

(b) a controlled drug that is subject to an Order's provisions that are described by Article 12(3) of the Misuse of Drugs (Jersey) Law 1978.

(2) Before approving the products or drugs, the Committee must consult the persons who it thinks it is appropriate to consult, including persons who have functions relating to, and knowledge of, medicinal products and controlled drugs.

59 System that holds individuals' records

The Committee must arrange for the development and maintenance of a system that –

(a) holds individuals' records and other information for the period, and in the way, specified in the requirements described in Article 61(a)(iii); and

(b) may or may not be electronic, either wholly or partly.

60 Register of assisted dying practitioners and certifying doctors

(1) The Committee must arrange for the development and maintenance of a register that –

(a) records each person who is in the role of a type of assisted dying practitioner or of a certifying doctor; and

(b) may or may not be electronic, either wholly or partly.

(2) The Committee must ensure that the Service registers information, and deals with the register, appropriately.

61 General information, standards for services and retention requirements

The Committee –

(a) must arrange for the Service or another supplier to develop or amend the following information –

(i) general information about the assisted dying process, including the information set out in Schedule 1;

(ii) standards for services in relation to assisted dying, and procedures for investigating and resolving complaints about the services that they or others have received; and

(iii) requirements for retaining individuals' records and other information held by the Service (including the period for which, and the way in which, the information must be retained);

(b) must require the Service or other supplier to consult the persons required by Article 67 in developing or amending the information;

(c) may approve the information;

(d) must –

(i) decide that the approved information should be made available to the public under Article 68; or

(ii) decide that the approved information should be made available only to relevant persons under Article 69, and decide the further matters under that Article; and

(e) must arrange for the Service or another supplier to publish, or make available, the approved information in that way.

62 Operational guidance

(1) The Committee –

(a) may arrange for the Service or another supplier to develop or amend operational guidance on a matter, meaning guidance about how a professional is to comply with a requirement, or carry out a practical matter, under this Law in relation to assisted dying;

(b) must require the Service or other supplier to consult the persons required by Article 67 in developing or amending the operational guidance;

(c) may approve the operational guidance;

(d) may –

(i) decide that the operational guidance should be made available to the public under Article 68; or

(ii) decide that the operational guidance should be made available only to relevant persons under Article 69, and decide the further matters under that Article; and

(e) may arrange for the Service or another supplier to publish, or make available, the approved operational guidance in that way.

(2) There must be operational guidance about –

(a) the right to refuse to participate in assisted dying;

(b) having appropriate conversations with patients about assisted dying;

(c) holding, indexing and giving access to individuals' records;

(d) the registration of assisted dying practitioners;

(e) the places of assisted deaths;

(f) independent advocacy, communication support and support for interpretation of languages;

(g) assessing individuals for assisted dying;

(h) care planning for individuals;

(i) prescribing and dispensing approved drugs;

(j) administering approved drugs, including detailed protocols for how to deal with a medical complication;

(k) donating organs;

(l) disclosing interests and deciding whether they conflict; and

(m) disclosing information about health professionals to a body that regulates their profession or to an enforcement authority (in Jersey or elsewhere).

(3) There may be operational guidance about another matter only if the Minister agrees to that.

(4) A person's compliance with, or breach of, operational guidance –

(a) does not in itself mean that they have complied with, or breached, a requirement under this Law; but

(b) may be used as evidence in –

(i) the prosecution of an offence (in Jersey or elsewhere);

(ii) disciplinary proceedings about a health professional's practice by their employer or a body that regulates their profession (in Jersey or elsewhere); or

(iii) disciplinary proceedings about a care navigator's performance by their employer.

63 General guidance

(1) The Committee –

(a) may arrange for the Service or another supplier to develop or amend general guidance on a matter, meaning guidance about how someone who is not, or is not acting as, a professional is to carry out a practical matter under this Law in relation to assisted dying;

(b) must require the Service or other supplier to consult the persons required by Article 67 in developing or amending the general guidance;

(c) may approve the general guidance;

(d) may –

(i) decide that the general guidance should be made available to the public under Article 68; or

(ii) decide that the general guidance should be made available only to relevant persons under Article 69, and decide the further matters under that Article; and

(e) may arrange for the Service or another supplier to publish, or make available, the approved general guidance in that way.

(2) There must be general guidance for families and carers of an individual.

64 Competencies

(1) The Committee –

(a) may arrange for the Service or another supplier to develop or amend the competencies that are required to perform the role of an assisted dying practitioner or a certifying doctor;

(b) must require the Service or other supplier to consult the persons required by Article 67 in developing or amending the competencies;

(c) may approve the competencies;

(d) may –

(i) decide that the approved competencies should be made available to the public under Article 68; or

(ii) decide that the approved competencies should be made available only to relevant persons under Article 69, and decide the further matters under that Article; and

(e) may arrange for the Service or another supplier to publish, or make available, the approved competencies in that way.

(2) The competencies must specify requirements relating to –

(a) capabilities, including –

(i) professional skills (such as practical, communication and clinical skills);

(ii) professional knowledge; and

(iii) professional values and behaviours (such as those relating to professional and ethical responsibilities and safeguarding vulnerable patients);

(b) training (other than training developed under this Law) and professional qualifications; and

(c) being professionally registered (such as the duration of registration).

(3) There must be competencies for –

(a) an assessing doctor;

(b) an administering practitioner;

(c) a pharmacy professional;

(d) an extended team member; and

(e) a certifying doctor.

(4) But there may be separate competencies for other roles, including a role within a wider role covered by paragraph (3), as the Committee thinks appropriate.

65 Training for professionals involved in assisted dying

(1) The Committee –

(a) must arrange for the Service or another supplier to develop or change the following training that must be completed by an assisted dying practitioner, a certifying doctor or a care navigator –

(i) the initial training required before registration with the Service;

(ii) the continuing training required, at the intervals set by the Committee, to remain registered with the Service;

(b) must require the Service or other supplier to consult the persons required by Article 67 in developing or changing the training;

(c) may approve the training; and

(d) must arrange for the Service or another supplier to provide the approved training.

(2) There must be training that covers –

(a) the aspects of the assisted dying process that are relevant for each role, including training about –

(i) the requirements of this Law;

(ii) operational guidance;

(iii) risk; and

(iv) the safety and well-being of the professional performing the role;

(b) the technical knowledge required to perform each role, such as –

(i) the administration of approved drugs by an administering practitioner, including how to deal with a medical complication; or

(ii) the certification of an individual's assisted death by a certifying doctor;

(c) domestic abuse and whether someone has been coerced or pressured to do something, including coercive control and financial abuse.

(3) The Committee must set the intervals at which the continuing training must be completed for each role.

66 Other training

(1) The Committee –

(a) must arrange for the Service or another supplier to develop or change training on having appropriate conversations with patients about assisted dying;

(b) may arrange for the Service or another supplier to develop or change training on other matters relating to assisted dying;

(c) must require the Service or other supplier to consult the persons required by Article 67 in developing or changing the training;

(d) may approve the training; and

(e) must arrange for the Service or another supplier to provide the approved training.

(2) The training is intended for –

(a) assisted dying practitioners, certifying doctors and care navigators; and

(b) anyone else who provides health or care services in Jersey and wants to complete the training.

67 Consultation on documents and training

(1) This Article specifies who the Service or other supplier must consult –

(a) in developing or amending information, guidance or competencies; or

(b) in developing or changing training.

(2) They are –

(a) the persons (if any) that the Committee or the Minister requires it to consult; and

(b) anyone else that the Service or other supplier thinks it is appropriate to consult.

(3) In deciding on the persons who should be consulted, the Committee, the Minister, the Service or the other supplier must take into account each person's functions and knowledge of health professionals' practice.

68 Publication of documents for public

(1) This Article applies if the Committee decides that approved information, guidance or competencies should be made available to the public.

(2) The approved information, guidance or competencies are to be published –

(a) electronically, including on a website maintained by or for the Committee; and

(b) in a style and format that is accessible, meaning that the individual or group for which they are intended is able to read or receive them and understand them (and which may include alternative formats, such as large print or braille).

69 Publication of documents for relevant persons

(1) This Article applies if the Committee decides that approved information, guidance or competencies ("documents") should be made available only to relevant persons.

(2) The Committee must decide –

(a) who are the relevant persons to whom the documents are to be made available;

(b) the extent of the documents to be made available; and

(c) the way in which the documents are to be made available.

(3) The documents may be made available in full or part to all or some relevant persons (for example, practitioners may have access to all, but others have access to only some, parts of the competencies).

(4) The documents may be made available in any form that the Committee thinks is appropriate (for example, by provision of a paper copy or a link to a website).

(5) In deciding matters under this Article, the Committee must –

(a) consider whether any person could misuse the documents (for example, by using information about assessments to manipulate the assisted dying process); and

(b) consult the Minister.

70 Support for individuals, connected people and professionals

(1) The Committee must arrange for the Service or another supplier to develop and provide support (such as counselling) for –

(a) individuals and their connected people; and

(b) assisted dying practitioners, certifying doctors and care navigators.

(2) The purpose of the support is to help the person deal with any negative effects of their involvement in the assisted dying process.

71 Investigation of professionals

The Committee may, in accordance with Regulations made under this Law –

(a) investigate the practice of an assisted dying practitioner or a certifying doctor, or the performance of a care navigator, so far as it relates to assisted dying; and

(b) after investigating –

(i) recommend the suspension or cancellation, or the ending of the suspension, of the person's registration for a role under Article 85; or

(ii) take other action in relation to the person.

72 Disclosure of information

(1) The Committee must not disclose information about the practice of an assisted dying practitioner or a certifying doctor, or the performance of a care navigator, that it receives from the Service, from its own investigations or otherwise.

(2) But the Committee may disclose the information as allowed by Article 41(2)(a) to (g).

(3) The Committee must have regard to the operational guidance referred to in Article 62(2)(m) (about disclosing information about health professionals to a body that regulates their profession or an enforcement authority) for any relevant disclosure of information.

73 Collection and analysis of information

(1) The Committee must collect and analyse information about assisted dying, including information about –

(a) each individual who requests assisted dying and the outcome of their assisted dying process;

(b) the Service's compliance with this Law and how it has regard to the operational guidance approved under this Law;

(c) the Service's compliance with its standards for services in relation to assisted dying; and

(d) the Service's investigation and resolution of complaints about the services that people have received.

(2) The Committee must collect and analyse the information for the purpose of –

(a) identifying any trends or issues with assisted dying (such as whether requests for assisted dying by individuals with similar conditions indicates a problem with treatment or care for the condition);

(b) reporting under Articles 74 and 75; and

(c) assuring the proper provision of services relating to assisted dying.

(3) The Committee must, before the Service is established, consult the Medical Officer of Health about how it should collect and analyse information under this Article.

74 Reports each year

(1) The Committee must report the following information to the Minister and the Care Commission for each year –

(a) the number of individuals who made a first request for assisted dying (by completing step 1);

(b) the number of individuals whose requests for assisted dying were approved (at step 5);

(c) the number of individuals who withdrew their request for assisted dying under Article 15, and the step in the assisted dying process at which each request was withdrawn;

(d) the number of individuals who died from an assisted death, separately by –

(i) whether approved drugs were administered by themselves or by the administering practitioner; and

(ii) how the approved drugs were administered, such as swallowing or injection;

(e) the number of assessments done for each individual and in total, whether at step 2 (first assessment) or step 3 (independent assessment), including –

(i) second opinion assessments done under Article 33; and

(ii) relevant opinions of professionals, whether or not involving examination, given under Article 31;

(f) for each individual to whom approved drugs were administered –

(i) the period between the approval of their request for assisted dying and their assisted death; and

(ii) the medical complications (if any) during or after the administration of the drugs;

(g) for each individual and in total, the number of appeals made to the Royal Court under Article 42 and the grounds for and outcomes of the appeals;

(h) personal details about all individuals who made a first request for assisted dying, all individuals whose requests for assisted dying were approved, all individuals who withdrew their request for assisted dying and all individuals who died from an assisted death, such as the following –

(i) age;

(ii) gender;

(iii) physical condition expected to cause their death;

(iv) use of end-of-life or other palliative care when they made the first request for assisted dying;

(v) main language and any additional languages used;

(vi) use of independent advocacy and communication support;

(vii) a protected characteristic under the Discrimination (Jersey) Law 2013;

(i) any other information about assisted dying that the Committee decides on.

(2) The Committee must, before the Service is established, consult the Medical Officer of Health about –

(a) which personal details of individuals should be reported under paragraph (1)(h), and particularly under paragraph (1)(h)(vii); and

(b) which additional information should be reported under paragraph (1)(i).

(3) The Committee must give each report to the Minister and the Care Commission no later than 31 March in the year after the year to which the report relates.

(4) The Minister must, as soon as reasonably practicable after receiving a report –

(a) consult the Medical Officer of Health about –

(i) which information in the report should be published, especially to prevent disclosure of information described in Article 41(1) (about people or approved drugs); and

(ii) the format in which information in the report should be published; and

(b) publish some or all of the information in the report –

(i) electronically, including on a website maintained by or for the Minister; and

(ii) in a style and format that is accessible, meaning that the individual or group for which it is intended is able to read or receive it and understand it (and which may include alternative formats, such as large print or braille).

75 Other reports

The Committee –

(a) must report to the Minister on any matter relating to assisted dying, as requested by the Minister; and

(b) may report to the Minister on any matter relating to assisted dying, as it thinks appropriate.

76 Requests for, and responses to, Review Panel's reviews

(1) The Committee may request that the Review Panel review (under Article 94(1)(b)) an individual's assisted dying process that ended before their assisted death for the purpose of ensuring that the Service operates in compliance with this Law and having regard to operational guidance approved under this Law.

(2) The Committee –

(a) must consider the decisions, findings and recommendations (if any) in a report that it receives from the Review Panel under Article 94 or 95;

(b) may accept and act on a recommendation, or reject a recommendation and do anything else that it thinks best; and

(c) must send to the Care Commission a copy of the report, details of the action it proposes to take (if any) and its reasons for taking or not taking action.

DIVISION 4 – SERVICE AND ITS FUNCTIONS

77 Service established

(1) The Minister must make every effort to establish and maintain an Assisted Dying Service, regardless of their or others' views about assisted dying.

(2) The provider of the Service must be –

(a) Health and Care Jersey, acting for the Minister; or

(b) if required by Regulations, another provider.

(3) If the Minister cannot establish and maintain the Service, they must present a report to the States Assembly stating –

(a) why they think the Service cannot currently be established and maintained;

(b) what they have done, and still intend to do, to try to establish and maintain the Service; and

(c) what they recommend is decided by the States Assembly to help the Minister to try to establish and maintain the Service.

(4) Before presenting the report, the Minister must consult the persons that the Minister thinks are representative of those affected by the establishment or absence of the Service.

78 Service has exclusive functions and fees are restricted

(1) The Service must provide assisted dying by arranging for the assisted dying process to be carried out for individuals, including by arranging the provision of the following, as required by the Committee –

(a) the services of assisted dying practitioners, certifying doctors and care navigators;

(b) support (such as counselling) relating to assisted dying for individuals and their connected people and for assisted dying practitioners, certifying doctors and care navigators; and

(c) independent advocacy, communication support and support for interpretation of languages.

(2) No other person may provide, or purport to provide, assisted dying.

(3) A person who, in any way (including in writing or by broadcast), promotes or advertises assisted dying or the Service –

(a) may do so only by giving information –

(i) about the availability of assisted dying and related services;

(ii) about where more information on assisted dying can be found;

(iii) about their role in assisted dying; or

(iv) that supports awareness and understanding of assisted dying; and

(b) must not do so with the intention of persuading or encouraging anyone to have an assisted death.

(4) The Service must not charge an individual for any part of the assisted dying process except as allowed by Regulations (if any).

79 Keeping and giving access to individuals' records

(1) The Service must keep an individual's records.

(2) The Service must give access to, or copies of, an individual's records to –

(a) the relevant persons, and to the extent and in the way, that the Committee decides upon under Article 69, which applies as if the records were documents to which that Article applies;

(b) the Review Panel, for the purposes of a review under Article 94; and

(c) the Care Commission, for the purposes of an inspection, or its decision whether to inspect, under the Regulation of Care (Jersey) Law 2014.

80 Registration of assisted dying practitioners and certifying doctors

(1) A person may apply in writing to the Service to register them as –

(a) 1 or more of the following types of assisted dying practitioner –

(i) a co-ordinating doctor;

(ii) an assessing doctor who is not a co-ordinating doctor;

(iii) an administering practitioner;

(iv) a pharmacy professional;

(v) an extended team member; or

(b) a certifying doctor.

(2) The application –

(a) must contain, or be accompanied by, the information required by the Committee or under this Law;

(b) must contain the person's statement that they believe that the information is true and complete;

(c) must be made in the form (if any) approved by the Committee; and

(d) must be signed by the person.

(3) The Service must register a person for a role if it is satisfied that –

(a) it has the information required to register the person;

(b) the person has the competencies required for the role;

(c) the person has completed the initial training for the role under this Law;

(d) the person has complied with Article 82 and is not, in an interests review officer's opinion, someone who should not perform the role; and

(e) if applicable, the person has a responsible officer (under the Medical Practitioners (Registration) (Responsible Officers) (Jersey) Order 2014).

81 Renewal of registration of assisted dying practitioners

(1) An assisted dying practitioner may apply in writing to the Service to renew their registration by applying no earlier than 9 months, and no later than 15 months, after their most recent registration date.

(2) The application –

(a) must contain, or be accompanied by, the information required by the Committee or under this Law;

(b) must contain the person's statement that they believe that the information is true and complete;

(c) must be made in the form (if any) approved by the Committee; and

(d) must be signed by the person.

(3) The Service must renew a person's registration if it is satisfied that –

(a) it has the information required to renew the registration;

(b) the person still has the competencies required for the role;

(c) the person has completed the continuing training for the role under this Law at the intervals set by the Committee;

(d) the person has complied with Article 82 and is not, in an interests review officer's opinion, someone who should not perform the role; and

(e) the person still has a responsible officer (under the Medical Practitioners (Registration) (Responsible Officers) (Jersey) Order 2014).

(4) The Service must record the date on which the registration is renewed as the day that is 12 months after the person's most recent registration date.

(5) If a practitioner's registration is not renewed by the day that is 14 months after their most recent registration date, the Service must give them a written notice warning them about the periods in paragraphs (1) and (6).

(6) If an assisted dying practitioner does not renew the registration for their role, their registration ends 18 months after their most recent registration date.

(7) A person's "most recent registration date" is the day on which –

(a) they were first registered for their role, if it has never been renewed; or

(b) their registration was most recently renewed.

82 Disclosure of interests for registration

(1) This Article requires certain people to –

(a) complete and sign a form disclosing their interests (if any) that might, or might be seen to, conflict with any individuals' interests in the assisted dying process; and

(b) give the form to the Service.

(2) The people are anyone who –

(a) is applying to be registered for a role;

(b) is an assisted dying practitioner applying to renew their registration for a role; or

(c) is registered for a role and becomes aware that there has been a relevant change in their interests.

(3) If the person's form discloses 1 or more interests –

(a) the Service must give it to an interests review officer; and

(b) the officer must review the form and decide whether the disclosed interests might, or might be seen to, conflict with any individuals' interests in their assisted dying process to such an extent that, in the officer's opinion, the person should not perform the role.

83 Information on register

(1) The Service must record the following information on the register for each person registered for a role –

(a) their name;

(b) their role;

(c) the name of the body that regulates their profession, and the number (if any) given to them as professionally registered, in –

(i) Jersey; and

(ii) the United Kingdom;

(d) whether their contract of employment with the Service is a contract of direct employment or a contract for service;

(e) the interests (if any) that they disclosed in their most recent form under Article 82;

(f) the date on which they were first registered for the role;

(g) for an assisted dying practitioner who has renewed their registration, the 1 or more dates on which it was renewed;

(h) the dates on which they completed their initial training, and any continuing training, for the role under this Law;

(i) the date by which they must complete their next continuing training under this Law; and

(j) the date on which their registration for the role ended and the reason it ended, if applicable.

(2) The Service must record information on the register as soon as reasonably practicable after receiving it, as required by the Committee or under this Law.

84 Changes to details on registers

(1) An assisted dying practitioner or a certifying doctor must tell the Service –

(a) as soon as reasonably practicable after it happens –

(i) that they are suspended from being professionally registered (in Jersey or the United Kingdom);

(ii) that they are no longer professionally registered (in Jersey or the United Kingdom); or

(iii) that their professional registration (in Jersey or the United Kingdom) has had conditions or restrictions imposed on it; or

(b) within 7 days after becoming aware of it, that something has happened that may affect their professional registration (in Jersey or the United Kingdom) or their registration with the Service.

(2) An assisted dying practitioner or a certifying doctor must tell the Service, as soon as reasonably practicable after it happens, that any other information recorded on the register for them has changed.

(3) The person must tell the Service something under paragraph (1) or (2) by –

(a) giving written notice of it to the Service; or

(b) including it in an application to renew their registration.

85 Suspension or cancellation of registration

(1) The Service must –

(a) suspend a person's registration for a role if they are suspended from being professionally registered (in Jersey or the United Kingdom); or

(b) end the suspension of the person's registration for the role if their suspension from being professionally registered ends.

(2) The Service must cancel a person's registration for a role if they are no longer professionally registered (in Jersey or the United Kingdom).

(3) The Service may suspend or cancel, or end the suspension of, a person's registration for a role as recommended by the Committee under Article 71.

86 Surrender of registration

The Service must remove a person's registration for a role as soon as reasonably practicable after they apply in writing to the Service for that removal.

87 Disclosure of information on register or about practice

(1) The Service must ensure that the following information is not disclosed –

(a) information on the register (to protect the privacy of the people registered on it);

(b) information it holds about the practice of an assisted dying practitioner or a certifying doctor or the performance of a care navigator.

(2) But the Service may disclose the information –

(a) to the Committee; or

(b) to anyone else as allowed by Article 41(2)(a) to (g).

88 Development and publication or provision of documents and training

(1) The Service must, if and as required by the Committee –

(a) develop or amend information, guidance or competencies ("documents");

(b) consult persons in developing or amending the documents;

(c) have the documents approved by the Committee; and

(d) publish, or make available, the documents.

(2) The Service must, if and as required by the Committee –

(a) develop or change training;

(b) consult persons in developing or changing the training;

(c) have the training approved by the Committee; and

(d) provide the training.

89 Publication of forms

The Service must publish the forms to which Article 99 applies, as required by the Committee.

DIVISION 5 – REVIEW PANEL AND ITS FUNCTIONS

90 Review Panel established

(1) The Minister must establish and maintain an Assisted Dying Review Panel by appointing the number of members that are required by Order and in the way required by Order.

(2) The Minister may appoint a person as a member only if the person –

(a) has the knowledge and expertise in certain areas, as specified by Order; and

(b) is recommended by the Committee.

(3) The Committee may recommend a person as a member, whether or not they are a States' employee or another employee, as long as the Committee is satisfied that the person's interests do not conflict with any individuals' interests in the assisted dying process.

91 Terms of reference

(1) The Minister –

(a) must arrange for the Committee to develop, and may arrange for the Committee to amend, the Review Panel's terms of reference that set out its procedures for performing its functions and obligations, such as –

(i) its schedule for meetings;

(ii) how it votes and makes decisions; and

(iii) how it resolves a conflict of interest; and

(b) may approve the terms of reference, giving effect to them.

(2) Before approving the terms of reference, the Minister must consult the following bodies or people (or their equivalents) –

(a) the Care Commission; and

(b) anyone else who the Minister thinks it is appropriate to consult.

92 Remuneration of members

(1) The members of the Review Panel, other than members who are States' employees, must be –

(a) paid the remuneration (if any) that is set by, or calculated in accordance with, a decision of the Minister; and

(b) repaid for the reasonable expenses that they claim.

(2) The annual income of the States of Jersey must be used to –

(a) make those payments; and

(b) pay the expenses for the administration of the Review Panel.

93 Functions and obligations

(1) The Review Panel's functions and obligations are as set out in this Division.

(2) The Review Panel must follow the procedures in its terms of reference when performing its functions and obligations.

94 Report from review of completed assisted death or incomplete assisted dying process

(1) The Review Panel must review –

(a) each individual's assisted death that is carried out;

(b) an individual's assisted dying process that ended before their assisted death, if requested by the Committee.

(2) In reviewing an individual's assisted death or assisted dying process, the Review Panel –

(a) must review all of the individual's records;

(b) may request and, if provided, review relevant information from any person; and

(c) must decide whether the individual's assisted dying process complied with this Law and had regard to operational guidance approved under this Law.

(3) After its review, the Review Panel must report to the Committee –

(a) its decisions and findings from the review; and

(b) its recommendations (if any) to deal with its findings, and its reasons for the recommendations.

(4) A review must otherwise comply with the procedures and time frames (if any) provided by Order.

95 Report from analysis of reviews of assisted deaths

(1) The Review Panel must, when reasonably practicable, analyse the reports from 2 or more of its reviews to decide whether to recommend –

(a) any general changes or improvements in the assisted dying process; or

(b) any potential investigation into, or proceedings about, a professional's practice or performance.

(2) After its analysis, the Review Panel must report to the Committee –

(a) its decisions and findings from the analysis; and

(b) its recommendations (if any) to deal with its findings, and its reasons for the recommendations.

PART 4

SECONDARY LEGISLATION, FORMS AND FINAL MATTERS

96 Regulations

(1) The States may by Regulations –

(a) provide for the appointment of independent advocates to help individuals in relation to a request for, or the process of, assisted dying, and provide for –

(i) how an independent advocate can help an individual (for example, by providing support and advocacy for the individual to understand options for, or aspects of, end-of-life or other palliative care or assisted dying or to convey the individual's views and wishes about them);

(ii) which individuals qualify for help from an independent advocate;

(iii) how an advocate is independent (for example, by being independent of all others who have a personal or professional relationship with the individual);

(iv) who appoints an independent advocate and how they are appointed;

(v) the training that must be completed by an independent advocate;

(vi) the professional qualifications that an independent advocate must have;

(vii) the payment of remuneration to, and for the expenses of, an independent advocate;

(b) specify an activity that must not be done in a safe access zone (see Article 40), such as doing anything intentionally or recklessly –

(i) to obstruct someone's involvement in the assisted dying process; or

(ii) to harass someone for their involvement in, or contact with someone involved in, the assisted dying process;

(c) define a safe access zone at, and near, a place at which –

(i) any part of the assisted dying process is carried out;

(ii) the Service operates; or

(iii) an assisted dying practitioner, a certifying doctor or a care navigator is employed;

(d) specify the period during which activities must not be done in a safe access zone, whether a limited period or always;

(e) define the safe access zone as –

(i) particular boundaries around a particular place; or

(ii) a class of zones with certain features (for example, the area within 100 metres of the boundary of any private property at which an individual's assisted death is to be carried out);

(f) amend Part 2 or Article 1, or insert or delete a provision of this Law, to cover matters similar to the matters covered in Part 2, but only if the amendments do not affect whether an individual is eligible for assisted dying and are required to give effect to a recommendation that is –

(i) made by the Review Panel under Article 95(1)(a); and

(ii) accepted by the Committee under Article 76(2)(b);

(g) amend Article 41, 72 or 87, or insert or delete a provision of this Law, to change the information that a person is banned from disclosing and any exceptions to the ban;

(h) amend Article 48, 49 or 50, or insert or delete a provision of this Law, to change an offence, or create a new offence, in relation to –

(i) purporting that something or someone is an assisted dying practitioner, a certifying doctor, a care navigator or the Service; or

(ii) promoting or advertising assisted dying or the Service;

(i) amend Part 3, Division 3, or insert or delete a provision of this Law, to change the functions or obligations that the Committee must perform in relation to assisted dying (including to remove all functions and obligations if the Service cannot be established or maintained);

(j) provide for how the Committee may, for the purposes of Article 71 –

(i) investigate a person's practice or performance; and

(ii) after investigating, recommend the suspension or cancellation, or the ending of the suspension, of the person's registration for a role, or take other action in relation to the person;

(k) require the Service to be provided by another provider, for the purposes of Article 77(2)(b);

(l) provide for the transfer, from the existing provider to the new provider, of employees, equipment, facilities, individuals' records, responsibility for individuals or anything else related to the Service;

(m) amend any of the following provisions, or insert or delete a provision of this Law, to cover matters similar to the matters covered in those provisions, but

only if the amendments do not affect whether an individual is eligible for assisted dying and are required because of changing the provider of the Service –

(i) Article 1 (interpretation);

(ii) Articles 19 to 22 (disclosure of interests in relation to individuals or independent assessments);

(iii) Article 34 (prescribing, preparing and dispensing approved drugs);

(iv) Article 41 (disclosure of information about people or approved drugs);

(v) Part 3, Division 3, 4 or 5 (Committee, Service or Review Panel and their functions);

(n) amend another enactment as a consequence of changing the provider of the Service;

(o) amend Part 3, Division 5, or insert or delete a provision of this Law, to change the functions or obligations that the Review Panel must perform in relation to assisted dying (including to remove all functions and obligations if the Service cannot be established or maintained);

(p) require an individual to pay a fee for all or part of the assisted dying process;

(q) create an offence for a breach of this Law, or of Regulations or an Order made under this Law, with a penalty no greater than a fine of level 3 on the standard scale;

(r) create a civil remedy, for an employee or a partner who experiences detriment under Article 38, that can be awarded by a tribunal or a court, including matters such as –

(i) a right to compensation or continued employment or partnership (as under Article 77 of the Employment (Jersey) Law 2003, for example);

(ii) provision for appeals; or

(s) provide for matters that are consequential on, or for the transition that occurs on, this Law coming into force or the Regulations coming into force.

(2) The Minister must, before lodging a proposition containing draft Regulations to be made –

(a) under paragraph (1)(b) to (e) –

(i) be satisfied that the specified activities and periods, and defined zones, are only as broad as is required to preserve the safety of people involved in, or the integrity of, the Service, the Committee, the Panel or the assisted dying process, while preserving the people's privacy as far as reasonably practicable; and

(ii) consult the persons that the Minister thinks it is appropriate to consult;

(b) under paragraph (1)(k) –

(i) be satisfied that the new provider can provide the Service effectively, efficiently and in accordance with this Law;

(ii) be satisfied that, under the terms on which the new provider will provide the Service, the Minister will remain accountable for the Minister's obligation about maintaining the Service; and

(iii) consult the persons that the Minister thinks are representative of those affected by the change of providers; or

(c) under paragraph (1)(p), be satisfied that charging the fee is consistent with any charging for other health and care services provided by Health and Care Jersey.

97 Orders

(1) The Minister may by Order –

(a) specify a place, other than in Jersey, at which a person must or may be for a specified meeting held under this Law, for the purposes of Article 18(2);

(b) require or allow a specified meeting held under this Law to be held electronically, instead of in person (between people at the same place), for the purposes of Article 18(3)(b);

(c) amend Article 54, or insert or delete a provision of this Law, to change anything relating to the appointment or membership of the Committee, such as –

(i) the minimum and maximum number of members;

(ii) who appoints members and how they are appointed, including any requirements for consultation; or

(iii) the requirements that a person must meet to be appointed;

(d) amend Article 83, or insert or delete a provision of this Law, to change the information that must be recorded on the register;

(e) specify the minimum and maximum number of members of the Review Panel, and provide for how its members must be appointed, for the purposes of Article 90(1);

(f) specify the knowledge and expertise in certain areas that a person must have to be appointed as a member of the Review Panel, for the purposes of Article 90(2)(a);

(g) provide for the procedures and time frames for the Review Panel's review of an assisted death or assisted dying process, for the purposes of Article 94(4);

(h) amend Schedule 1 to change the information that must be included in the general information about the assisted dying process, for the purposes of Article 61(a)(i);

(i) specify information that must be contained in, or accompany, a form or an application under this Law; or

(j) provide for the transition that occurs when the Order comes into force.

(2) Before making an Order under paragraph (1)(d), the Minister must consult the Committee and whoever the Minister thinks it is appropriate to consult.

98 Rules of court

The power to make rules of court under Article 13 of the Royal Court (Jersey) Law 1948 includes a power to –

(a) regulate and specify the procedure for an appeal to the Royal Court under Article 42 (against a decision made under this Law);

(b) provide for those appeals that relate to the age and residency criteria, or relate to another matter specified by the rules, to be determined on the basis of only filed documents (and not an oral hearing); or

(c) provide for notices to be given so that a person can comply with Article 8(8) or 9(1)(i) (delay in assisted dying process during appeal by person with special interest).

99 Forms

(1) This Article applies to a form that an individual, an assessing doctor or any other person must or may complete and sign under this Law.

(2) The form must contain the information that –

(a) is required by this Law or by Order; or

(b) is required by the Committee, after consulting the Minister and anyone that the Committee thinks it is appropriate to consult.

(3) The form must be in the format, and on paper or electronic, as decided by the Committee.

100 Transitional provisions

Schedule 2 provides for the transition that occurs when this Law comes into force.

101 Amendments to other legislation

Schedule 3 makes amendments to other legislation that are related to this Law or are consequential on this Law coming into force.

102 Citation and commencement

(1) This Law may be cited as the Assisted Dying (Jersey) Law 202-.

(2) The following come into force 7 days after the Law is registered –

(a) Article 1 (interpretation);

(b) Articles 36 to 39 (right to refuse and protections);

(c) Articles 41(1)(c) and (2) and 52 (disclosing information identifying approved drugs);

(d) Part 3, Divisions 2 to 5, and Schedule 1 (protection and offences, Committee, Service, Review Panel and their functions);

(e) Articles 96 to 99 (Regulations, Orders, rules of court and forms);

(f) Article 100 and Schedule 2 (transitional provisions);

(g) Article 101 and Schedule 3, paragraphs 2, 5 and 6 (amendments to Homicide (Jersey) Law 1986, Regulation of Care (Jersey) Law 2014 and related Regulations);

(h) this Article.

(3) The rest of the Law comes into force on a day to be specified by the States by Act.

SCHEDULE 1

(Article 61(a)(i))

GENERAL INFORMATION ABOUT ASSISTED DYING PROCESS

The general information about the assisted dying process must include information about –

(a) the criteria for assisted dying;

(b) each step of the assisted dying process;

(c) the Service, including its contact details;

(d) the right to appeal certain decisions under this Law;

(e) how an individual, their connected person, an assisted dying practitioner, a certifying doctor or a care navigator can obtain support (such as counselling) relating to assisted dying;

(f) how someone may complain about the services that they or others have received; and

(g) matters that an individual may want to consider before their assisted death (such as life insurance or other personal administrative or financial matters).

SCHEDULE 2

(Article 100)

TRANSITIONAL PROVISIONS

1 Assisted dying provided only when Law fully commenced

Assisted dying must not be provided until all of this Law has come into force, despite Article 78(1) or another provision of this Law.

SCHEDULE 3

(Article 101)

AMENDMENTS TO OTHER LEGISLATION

1 Cremation (Jersey) Regulations 1961 amended

(1) This paragraph amends the Cremation (Jersey) Regulations 1961.

(2) In Regulation 6(a), after "cause of death" there is inserted "(attending practitioner)".

(3) In Regulation 6(a), after "5 years" there is inserted "(confirming practitioner)".

(4) In Regulation 6(a), there is deleted ", being neither a relative of the deceased nor a relative or partner of the practitioner who signed the first-mentioned certificate".

(5) After Regulation 6(c) the following is inserted, and the existing text is numbered as paragraph (1) –

(2) The confirming practitioner must not be –

(a) a relative of the deceased; or

(b) a relative or partner of the attending practitioner.

(3) If the deceased is an individual who had an assisted death under the Assisted Dying (Jersey) Law 202-, the attending practitioner must not be –

(a) a relative or partner of the individual's administering practitioner under that Law; or

(b) a relative or partner of the individual's certifying doctor under that Law.

(6) In Regulation 8, at the end, the following is inserted, and the existing text is numbered as paragraph (1) –

(2) But an assisted death under the Assisted Dying (Jersey) Law 202- does not count as a death that has, or might have, resulted from poison.

2 Homicide (Jersey) Law 1986 amended

(1) This paragraph amends the Homicide (Jersey) Law 1986.

(2) For Article 6(3)(b) there is substituted –

(b) an offence under Article 6A in which a person dies by suicide.

(3) After Article 6 there is inserted –

6A Suicide

(1) Suicide is not an offence.

(2) But a person commits an offence if they do an act that can, and is intended to, encourage or assist another person's suicide or attempted suicide.

(3) The person commits the offence whether or not –

(a) they know or can identify the other person; or

(b) the suicide or attempt happens.

(4) The person is liable to imprisonment for 14 years.

3 Inquests and Post-Mortem Examinations (Jersey) Law 1995 amended

(1) This paragraph amends the Inquests and Post-Mortem Examinations (Jersey) Law 1995.

(2) In Article 2(1)(c), after "registered medical practitioner" there is inserted "but not from an assisted death under the Assisted Dying (Jersey) Law 202-".

4 Marriage and Civil Status (Jersey) Law 2001 amended

(1) This paragraph amends the Marriage and Civil Status (Jersey) Law 2001.

(2) After Article 65(1) there is inserted –

(1A) But an assisted death under the Assisted Dying (Jersey) Law 202- cannot be notified –

(a) under paragraph (1)(c) on the basis that it is unnatural; or

(b) under paragraph (1)(e).

5 Regulation of Care (Jersey) Law 2014 amended

(1) This paragraph amends the Regulation of Care (Jersey) Law 2014.

(2) In Article 1(1), before the definition "certificate" there is inserted –

"assisted dying" means the services provided by the Assisted Dying Service under the Assisted Dying (Jersey) Law 202-;

(3) After Article 21 there is inserted –

21A Cancellation of registration relating to assisted dying service

(1) This Article applies if the cancellation of 1 or more peoples' registration in relation to the provision of assisted dying –

(a) would otherwise prevent the assisted death of an individual whose request for assisted dying has been approved under the Assisted Dying (Jersey) Law 202-; and

(b) does not relate to the practice of an assessing doctor involved in the individual's assisted dying process.

(2) The registration must be treated as if it were not cancelled but only for the purposes of allowing the individual's assisted death to be carried out.

(4) For Article 22(1) there is substituted –

(1) In this Article, "essential service" –

(a) means a regulated activity that is carried on by a Minister and not by any other person; but

(b) excludes the provision of assisted dying.

(5) In Schedule 1, Part 2 (Regulated activities: provision of care services), after paragraph 5 there is inserted –

5A Assisted dying

The provision of assisted dying is a regulated activity.

6 Regulation of Care (Standards and Requirements) (Jersey) Regulations 2018 amended

(1) This paragraph amends the Regulation of Care (Standards and Requirements) (Jersey) Regulations 2018.

(2) After Regulation 27 there is inserted –

PART 4A

ASSISTED DYING

27A Requirement in respect of provision of assisted dying

(1) This Regulation applies if the regulated activity is the provision of assisted dying, and for the purposes of Article 14 of the Law.

(2) The registered person must carry on the regulated activity in accordance with the Assisted Dying (Jersey) Law 202-.