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Assisted Dying Review Panel

Review of Assisted Dying

Witness: The Minister for Health and Social Services

Wednesday, 3rd April 2024

Panel:

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

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

Witnesses:

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

Ms. R. Johnson, Director of Health Policy, Government of Jersey

[11:16]

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

Good morning, everybody. This is a public hearing with the Assisted Dying Review Panel. We are speaking to the Minister for Health and Social Services today. My name is Deputy Louise Doublet. I am the chair of the panel. I will let my panel introduce itself.

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

Deputy Catherine Curtis, the vice-chair of the panel,

Acting Committee Officer:

Ben Walker, acting committee officer supporting the panel.

Deputy L.M.C. Doublet:

Minister, if you could introduce yourself and your officer.

The Minister for Health and Social Services:
Tom Binet, Minister for Health and Social Services.

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

Deputy L.M.C. Doublet:
Apologies for the late start. We have had some technical difficulties, but it should all be working now and being streamed live. The recording and transcript will be available afterwards on the States Assembly website. Could everybody please check that their electronic devices are switched off or on silent? When you speak, if you could state your name and role, but there are not many of you today so we should be fine with that. In terms of the topic under discussion today, if anybody … it can be a difficult topic to be listening to and considering. If anybody does need any support with the content of the hearing, support can be accessed via the Listening Lounge on 866793 and also Jersey Hospice on 876555. We do have 2 hours for this hearing. Can I just check your availability because we have started late because of the technical difficulties? Is everybody okay if we go over perhaps 10 minutes, and we will aim to finish by 1:10? Because given the contents of this topic, we have ...

The Minister for Health and Social Services:
If we could finish by 1:10, it just gives me enough time to get to the next one, that should be fine.

Deputy L.M.C. Doublet:
Absolutely. That is absolutely fine, thank you. Minister, the panel understands … sorry, before we start, I just wanted to give apologies from Deputy Sir Philip Bailhache. He would have liked to be here, but he is attending a funeral. Otherwise, he would have been here with the panel. We understand that the States Assembly, due to the amendment that was brought in the previous Assembly, there must be demonstration that the quality and availability of palliative and end-of-life services, prior to any assisted dying legislation coming into force. Please, can you explain how this requirement will be monitored, evidenced and highlighted in future Government Plans, as well as the strategy, the palliative care and end-of-life care strategy for adults in Jersey 2023 to 2026, in relation to demonstrating the quality and availability of the end-of-life and palliative care services?

The Minister for Health and Social Services:
I am not in a position to detail how that work will be undertaken, but it is my understanding that £2 million was assigned to improve palliative care provision and that if either one or other, or both of part (a) and (b) get passed, and it goes through the entire process, nothing can be enacted until such time as an assessment has been carried out that palliative care has improved. I know this is

something, like with most things on the subject, Ruth is going to know a lot more about the detail than I do. But, Ruth, you might want to elaborate a little bit on that.

Deputy L.M.C. Doublet:
Just before we do, in terms of your own personal assurances, what do you need to see personally to be reassured that those provisions are in place?

The Minister for Health and Social Services:
The very fact that that requirement is in place gives me some reassurance and, subject to the assessment that is undertaken being suitable, then I think everybody is being well served.

Deputy L.M.C. Doublet:
Could you just elaborate on the assessments?

The Minister for Health and Social Services:
That is why I was going to hand over to Ruth, because, at this stage again, that is still quite a long way away. That is up to 3 years away, if everything gets passed through. That, as I say, is some distance away. I am not quite sure … has a process actually been yet defined as to how that will be assessed?

Director of Health Policy, Government of Jersey:
Where we are, as you know, the States Assembly made the decision to invest an additional £2 million to £3 million per year in palliative and end-of-life care services. That money is underpinning the delivery of a new end-of-life and palliative care strategy that has been developed by a consortium of organisations, which includes the Jersey Hospice as the lead. That strategy, if it is not already published, is imminently being published.

Deputy L.M.C. Doublet:
It is.

Director of Health Policy, Government of Jersey:
It is published.

Deputy L.M.C. Doublet:
It is available, yes,

Director of Health Policy, Government of Jersey:

What that strategy does is that strategy has a number of long-term objectives. Those long-term objectives include elements such as 100 per cent of patients at home will have access to 24/7 model of palliative care. That 100 per cent of health and care professionals working across the community and in the hospital and hospice will have access to educational sessions around palliative care on a monthly basis. It also has other metrics in it, which is about 100 per cent of carers being supported through the palliative care experience of their loved ones. The strategy is underpinned by a number of metrics. Those are obviously very long-term objectives. What we are envisaging is at the point at which draft legislation is brought to the Assembly, that draft legislation will propose that the Assembly does not enact legislation until it has seen evidence that there is movement in the right direction against those and potentially other metrics, which we will work on over the next 2-year period. Clearly, because the end-of-life and palliative care strategy is a long-term strategy, they will not have met all those targets by that point in time. But what we would want the States Assembly to be assured of is that there was evidence that there was movement in the right direction to improving those services.

Deputy L.M.C. Doublet:

That is helpful, thank you. In terms of that assurance, what I would like to understand, Minister, what level of confidence do you have that those things will be in place short term or long term?

The Minister for Health and Social Services:

I have to say, thus far, a high level of confidence, and that is basically because I've been quite close to the process throughout. As you will see from the extent of the documentation, it has been a very, very comprehensive process.

Deputy L.M.C. Doublet:

Is this something that you will be keeping a watching brief on and monitoring as it goes along, given the importance of this to States Members and the public?

The Minister for Health and Social Services:

I will only be able to monitor it for the period of time for which I remain a States Member.

Deputy L.M.C. Doublet:

Of course.

The Minister for Health and Social Services:

I will probably be keeping a close eye on it aside of that as well, because, as you know, it is something that is close to my heart anyway, and the job needs to be done properly. It was of great interest to me before I came into the States, and it will remain so thereafter.

Deputy L.M.C. Doublet:

How will States Members be informed about whether the strategy and the future Government Plans … financing around the strategy? How will States Members be informed about whether that support is adequate?

The Minister for Health and Social Services:

Presumably that will appear in the report at the time when the report is produced. As I say, we are talking some 3-plus years away.

Director of Health Policy, Government of Jersey:

Yes. That is absolutely what we envisage at this point in time, is that when we bring the draft legislation, the draft legislation will have an addendum attached to it, which will explain delivery against that strategy achievements. If it is identified that there needs to be any changes in strategic direction, because of course we are talking about a quite long time period here, and if there are any amendments to that strategy that will all be set out in the addendum to the report and proposition at that time, so that States Members can make an informed decision about palliative care provision.

Deputy C.D. Curtis:

From this report, I saw that most people want to receive palliative care in their own homes, but most people receive it in hospital. So, there will have to be quite a lot of movement over the next few years if there is going to be something that will adequately cover what people want.

Director of Health Policy, Government of Jersey:

Yes, absolutely. That goes back to the fact that it is a long-term strategy. In 2 to 3 years' time, I think, and I will hasten to say that I am not a palliative care expert, but as I understand it, in 2 to 3 years' time you will not see that aspiration realised for all people. But you will see a development on that journey and a positive development on that journey.

The Minister for Health and Social Services:

If I could add to that. I think if you ask somebody, while they are well, what they would like to have as an ideal, that would be to be treated at home. But the sad reality is that an awful lot of people will end up in hospital taking … not an awful lot of people because the numbers are low anyway. But some people will suffer the misfortune of being in hospital when that happens, and it will not be appropriate for them to be at home. I think the aspiration at the beginning perhaps might not meet what is available to you at the end of life.

Deputy L.M.C. Doublet:

You have talked about that it is a long-term aspiration. But what information and assurances will States Members have before the debate on the legislative provisions? What will they have to inform their decision on that?

The Minister for Health and Social Services:
On 22nd May?

Deputy L.M.C. Doublet:
By the time the legislation is being debated.

Director of Health Policy, Government of Jersey:
What we would look at presenting to States Members is actual metrics, which look at what the current status quo is in terms of where people are dying, where people want to die, what their access to care is, and tracking the improvements in those metrics over that 2 to 3-year period.

Deputy L.M.C. Doublet:
In terms of keeping that strategy reviewed, there is an end-of-life care partnership group, which we note that that will be reconstituted and that there is an action plan within that strategy. Could you talk about how that strategy will be kept under review by that group?

The Minister for Health and Social Services:
I do not know, have we got a formal review process?

Director of Health Policy, Government of Jersey:
That is a level of detail that I do not have available. But we can certainly provide it to you because it is a different group of officers, but also a large group of external partners who are responsible for that piece of work. We can get that detail to the Scrutiny Panel.

Deputy L.M.C. Doublet:
I think, given the previous debate on this and the palliative and end-of-life care, the importance of those provisions being robust and being suitable, that came through quite strongly in the debate. That is something that I believe States Members would like to be kept informed on. So, if we could have the extra detail on how that will be kept under review.

Director of Health Policy, Government of Jersey:
Yes.

Deputy L.M.C. Doublet:

Is there sufficient officer resource in place to make sure that those pieces of work are, I think annually at least, kept under sufficient review?

The Minister for Health and Social Services:
You may have further comment, but my understanding is we have the resources that we need for the time being. As with all of these things, as they develop, they have to be reviewed, do they not?

Deputy L.M.C. Doublet:
Yes.

The Minister for Health and Social Services:
If there seems to be a shortfall in resource, then that would be flagged up and presumably further resources would be made available.

Deputy L.M.C. Doublet:
Is there a risk that the resources would not be available?

The Minister for Health and Social Services:
Not to my knowledge but, as you know, there are always cost pressures. With this piece of work, if it gets to the next stage, it is going to require what it requires to be done properly. It is not something where I think cost-cutting could apply.

Deputy L.M.C. Doublet:
What does it look like in terms of numbers of officers?

The Minister for Health and Social Services:
I would not have that detail.

Director of Health Policy, Government of Jersey:
Do you mean numbers of officers reviewing the delivery of the strategy?

Deputy L.M.C. Doublet:
Yes.

Director of Health Policy, Government of Jersey:
As per the previous question, the strategy working group is a cross-organisational working group. It is not just reliant on Government of Jersey officers. In terms of the detail of how that group are going

to monitor delivery of that strategy, I do not have that information available, but we can find it out and provide it to you.

The Minister for Health and Social Services:
The truth is the resource will continue throughout the process. It will extend as we go through the process, as more people get drawn into putting the whole procedure together. It is an ongoing cost. It would not be very easy to give you a precise, detailed timeline of when those costs will be incurred.

Deputy L.M.C. Doublet:
Okay. We have some questions in more detail around the areas of the strategy and the action plan. Some of them were marked as current or ongoing, and some were marked as not started.

[11:30]

Are you able to give us any more information or is that something we should seek in writing?

Director of Health Policy, Government of Jersey:
You would need to seek that information in writing because we do not have anyone with us who is leading on the development of the end-of-life and palliative care strategy.

Deputy L.M.C. Doublet:
We will, I think, come back to those ones in writing then.

Deputy C.D. Curtis:
The panel notes the possibility of placing a statutory duty on the Minister to provide palliative care and end-of-life care as part of the development of an adult safeguarding law. Please, can you provide more information about how this potential duty is being considered?

The Minister for Health and Social Services:
To be honest with you, 8 weeks in, I have not gone into that process myself. I do not know if you have any further information.

Director of Health Policy, Government of Jersey:
There is a piece of active policy development work that is going on at the moment that is being led by a policy development officer within my team, which is looking at scoping the remit of a potential adult safeguarding law. They are in the process of working out options for what the remit and the extent of that law would be in terms of the statutory duties that it will place on both the Minister for Health and Social Services, and on other Ministers, to protect vulnerable adults, and the extent of

the services involved. There are obviously clearly lots of different groups of vulnerable adults. For example, carers who are adults are considered vulnerable adults and adults with learning disabilities, et cetera. There are a whole range of different groups of vulnerable adults. What that working group is currently doing at the moment is identifying where are the key groups of vulnerable adults who are potentially at risk. What is the current access to the services that safeguard and protect their interests? Should those services be made statutory? Because at the moment most of them are not statutory. What would the associated costs be with that? Clearly people at end of life by dint of the fact that they are end of life would potentially be considered vulnerable. That is an active, ongoing piece of policy work. We would anticipate seeing that initial policy scoping process being finalised for consideration by the Minister in approximately about the next 6 months for there then to be further consultation around what could be within a draft law. Obviously, that would need to be costed because there are significant potential costing requirements associated with safeguarding all groups of adults.

Deputy C.D. Curtis:
Thank you. So, at the moment key stakeholders have not been consulted yet then, have they not?

Director of Health Policy, Government of Jersey:
No, we are at the very initial stages of doing the preliminary policy research find development. There has not been wider consultation at the moment. There will be wider consultation once that process has been stepped through.

Deputy C.D. Curtis:
That was interesting about possibly services being made statutory. Can you give any examples of that?

Director of Health Policy, Government of Jersey:
A bit like the provisions that went through to protect children where there were statutory duties placed on individual Ministers and individual officers to protect children and to take certain actions. It would be an adult's equivalent of that.

Deputy L.M.C. Doublet:
It is the equivalent of corporate parenting.

Director of Health Policy, Government of Jersey:
Yes, it would be. What we would look at doing is we would look at how we dovetail that with the arrangements for children as well, because we have made significant strides forward with the

protection and safeguarding of children within law, and that is not reflected yet in vulnerable adults. That is exactly the piece of work that we are currently looking at.

Deputy L.M.C. Doublet:
It sounds like a very big piece of work.

Director of Health Policy, Government of Jersey:
It is a very big piece of work, yes. Obviously the very starting point of that is the question of how far do we go?

Deputy C.D. Curtis:
Just one more question on that. How will the risks identified and the responses to those risks be tracked and managed once confirmed through the risk assessment process? This is probably something for later on.

Director of Health Policy, Government of Jersey:
The risks associated with what, sorry?

Deputy C.D. Curtis:
The risks and responses associated with this whole law that is coming into place.

Director of Health Policy, Government of Jersey:
Is it the adult safeguarding law or the Assisted Dying Law?

Deputy C.D. Curtis:
The adult safeguarding law.

Director of Health Policy, Government of Jersey:
At that stage, because it is such a preliminary stage in the process, we cannot provide that information, but we would be really happy to come and brief the Health and Social Security Panel on more detail about that work and the progress that we are making.

Deputy L.M.C. Doublet:
Just a quick political question, Minister. Do you think that a statutory duty should be put in the law in terms of adult safeguarding, along the same lines as children, corporate parent?

The Minister for Health and Social Services:

Probably, yes. As I say, I am not close enough to this to give you a completely informed answer. As I say, 2 months into the job has been an awful lot to get my head around. That is why you will find Ruth answering a lot of the very detailed points. I was not even aware of that piece of work happening, in fairness. That is off into a very detailed area.

Deputy L.M.C. Doublet:

But from what you have heard today, do you think probably …

The Minister for Health and Social Services:

From what I am hearing now, that certainly seems to make sense. But I really need to discuss that with Ruth and look at the cost implications and the wider implications before making a complete statement on it.

Deputy L.M.C. Doublet:

In terms of the different routes within the proposals - there is the route one, which is for terminal illness - could you provide some more information about the decision to specify neurodegenerative diseases in the proposals above any other diseases and conditions?

The Minister for Health and Social Services:

Is it specified above any other?

Director of Health Policy, Government of Jersey:

Under the proposals, life expectancy is 6 months for someone who has got a terminal illness, but 12 months for someone with a neurodegenerative disease. That is a development from the original proposals that the States voted for in principle. There are a number of clarifications and amendments to that original in-principle decision, and this is one of them. The reason why we introduced that is we have done a lot of research about the realities of how assisted dying works in other jurisdictions. We have spoken to practitioners in other jurisdictions and most other jurisdictions, or many other jurisdictions, have some kind of life expectancy. One of the things that was quite clear in those conversations is the practitioners were raising with us the particular risks of a 6-month life expectancy for people with neurodegenerative conditions. That is because of the disease trajectory. If you have something like muscular dystrophy, it is regrettably the case that your quality of life is going to diminish many, many months before you actually die. Hence, as a result, the proposal that for those categories of neurodegenerative diseases only that have those particular challenges around quality of life, there should be special provision of 12 months made.

Deputy L.M.C. Doublet:

I think that is very well explained in the proposals.

The Minister for Health and Social Services:
As Ruth said, it has not been prioritised, it has just been facilitated, is that not right?

Director of Health Policy, Government of Jersey:
Yes.

Deputy L.M.C. Doublet:
Sure. Were any other conditions or types of conditions considered for similar specific proposals? If they were, why were they not included? What we did was when we were looking at the timeframes, we were looking at the conditions that resulted in assisted deaths in other jurisdictions. The condition that most likely results in an assisted death in the case of someone who is terminally ill in another jurisdiction are the cancers, which I think we would probably anticipate just in terms of population numbers. There was not necessarily any compelling evidence from the information provided to us in practitioners in other jurisdictions that 6 months was a particular issue for those cancers. But it was the neurodegenerative diseases that kept on coming up with the … their advice and recommendations was 6 months is potentially very problematic for this particular cohort of people.

Deputy L.M.C. Doublet:
Were there any other conditions other than cancer or neurodegenerative that were considered?

Director of Health Policy, Government of Jersey:
We did look at a range of other conditions. You will have to excuse me; I cannot remember all of them off the top of my head. But in terms of the information provided to us in other jurisdictions, those were the 2 key categories that I can recall, and it was only the neurodegenerative diseases that raised these particular concerns.

Deputy L.M.C. Doublet:
Could we have that list of other conditions that were considered? Could we have that provided to us with any detail on the reasons why they were not provided for?

Director of Health Policy, Government of Jersey:
Yes.

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

Deputy C.D. Curtis:

This is about life expectancy still. It is going to provide more information about the differences in life expectancy requirement for neurodegenerative diseases and all other terminal illnesses, which include a 6-month life expectancy. I think you said …

The Minister for Health and Social Services:
We have basically covered that one.

Deputy L.M.C. Doublet:
We might have covered that one, yes. In terms of route 2, the unbearable suffering route, there were some conversations in the ethical review around the inclusion of this route and I think some differences in terms of the previous reports that had been published. The ethical review advised against the inclusion of this route 2, so I would like to ask you some questions about that, Minister. In terms of the reasons that the ethical review gave, one of the words they used was the term "ableist". Can you just outline what you understand that term to mean and how it might apply here?

The Minister for Health and Social Services:
To be to be fair, you are using a word which is out of context. I read that review quite some time ago, if I had read the paragraph in which that was included. But I am happy to talk about the principle of it and my …

Deputy L.M.C. Doublet:
Can I read the excerpt? It says it makes and reinforces an ableist judgment. So, route 2: "… makes and reinforces an ableist judgment about the negative value of the lives of people with disabilities."

The Minister for Health and Social Services:
That is a statement made by somebody else and you would have to ask them what they meant by that. I am not entirely sure, to be fair. I cannot really speak for someone else.

Deputy L.M.C. Doublet:
Feel free to take a moment to reflect on it, but it is important that you give your views as part of the hearing today. I would just like to understand your understanding of that term "ableist" and how it applies to …

The Minister for Health and Social Services:
As I say, you have given me a paragraph, but I would have to … if I had had time to re-read everything before I came today, I would have perhaps a little bit more of a view on that. Could you perhaps rephrase the question in such a way as you are asking me my opinion on something specific, because I find that quite awkward?

Deputy C.D. Curtis:
This was one of the main principles from the ethical review about why they did not support route 2.

The Minister for Health and Social Services:
If you can articulate that a little bit more clearly, I can give you my view. I am not frightened to give you a view. I just want to have a little bit more of an understanding of what you are driving at.

Deputy L.M.C. Doublet:
Do you agree with what the ethical review stated about route 2, making and reinforcing an ableist judgment about the negative value of lives of people with disabilities?

The Minister for Health and Social Services:
If that means what I think it means, then I do not particularly know.

Deputy L.M.C. Doublet:
Could you elaborate on why?

The Minister for Health and Social Services:
This is a matter of personal choice for an individual. So long as there are sufficient safeguards everywhere for everybody concerned, I do not really see this as being an issue. I have to say, with regard to the ethical review, and I will make my feelings a little bit better known, I read the biography of the 3 people concerned and, before I started reading their outcome, I guessed straight away what the outcome would be. When I read it through, it was the outcome I expected. I have gone public on saying that I think an ethical review was not perhaps the wisest of things to do because you could have chosen any combination of 3 ethicists and perhaps had a different outcome. It is the opinion of 3 people, and that is what their ethical opinion happens to be. How useful that is, as I say, this is a free vote, a democracy. If people want to take note of that and that informs them to the extent that they feel obliged to follow the ethical advice that has been given by these 3 people, that is a matter for them.

[11:45]

Deputy L.M.C. Doublet:
It might help at this point to reflect on the terms of reference of the panel. The purpose of the hearing is to allow you to explain your political decision making behind the proposals that you have put forward, so that should form the bulk of the hearing. We will be going into details of some of the

different documents that have been produced to try and understand various proposals and ideas that you have accepted from different recommendations or not accepted.

The Minister for Health and Social Services:

Which is fine. I am very clear about this. All I am doing is presenting the result of a process. I have not interfered with that process. Part of that process has delivered an ethical review, and it is for democratically elected people to make of that what they will. I have made no attempt to try and remove it or do anything else. The process has delivered something that I think is very comprehensive and very creditable. I do not have any issue with it, but I would just … you asked the question, I give you my view on that particular issue. That is just as an individual view. Each person that votes on it will be free to take their own view on it and attach whatever importance they see fit.

Deputy L.M.C. Doublet:

Today we are examining your views, Minister, not anybody else's, so that when States Members come to make their decision on the day of the debate, they can examine all of the evidence and yours. This is an opportunity for you to give in more detail than you might be able to in a speech, the rationale behind the proposals that you are presenting to the Assembly.

The Minister for Health and Social Services:

I have to make this clear, if I have not already, is that I hold my view as something separate. That my view has not informed the presentation of the proposals. I have taken the decision that those proposals should be presented as per the entire process. The process has delivered proposals, and those are the proposals that are coming through.

Director of Health Policy, Government of Jersey:

I wonder if it might be helpful if I just provide some factual information about the process of developing …

Deputy L.M.C. Doublet:

I will just pick up on something the Minister just said. If the proposals that are before the States Assembly are not your political views, Minister, whose are they?

The Minister for Health and Social Services:

They are the collective views of the process that has been undertaken on the Government's behalf. I hardly think it would be appropriate for me to put a set of proposals forward that reflected my personal view. My personal view is probably reasonably well-known, because I was heavily involved in the campaign to bring this law forward, but I do not think it is my place to impose my views on

anybody. As I say, the States voted to put a process in place. That process has run and I, as the Minister for Health and Social Services, are putting the net result of that process forward for people to vote on. Does that not seem appropriate?

Deputy C.D. Curtis:

Could I just say that part of that process included the ethical review, which did not recommend a route 2. So, there must have been a decision from you, presumably, to not go with that.

The Minister for Health and Social Services:]

Yes, but the ethical review was part of that process. It was part of that process. There was a recommendation from them to not recommend it. That is what they have done. They have not recommended it and that forms part of the presentation that comes forward to the democratically elected public. It is not for those 3 people to make a decision on our behalf. What we have done is we included their opinion for people to have their own opinion on that opinion. I think that is relatively straightforward. I think it is right and proper, to be honest with you. I think that is my duty.

Deputy L.M.C. Doublet:

Just so that we all have a shared understanding of our democratic processes, Ministers are responsible for making decisions on their proposals and indeed own those proposals that are lodged in their name and have political responsibility and accountability for those.

The Minister for Health and Social Services:

Absolutely. I do not have any problem with that.

Deputy L.M.C. Doublet:

The scrutiny function is there to hold Ministers to account for those decisions that are made. So, we do expect that accountability to be in place and for those questions to be answered today.

The Minister for Health and Social Services:

Forgive me, but there is an implication there that I am not answering your questions. Or perhaps I am not answering in the way that you want.

Deputy C.D. Curtis:

Shall I ask the next question?

Deputy L.M.C. Doublet:

Go ahead.

Deputy C.D. Curtis:

The next question, it carries on from what we are already talking about, which is what reflections can you make on the following extract from the ethical review, which is: "Allowing assisted dying on such a basis creates societally endorsed and medicalised ending of life for disabled persons who are otherwise not dying, thereby signalling that a life with disability is less worth living and/or more intolerable than a life without a disability." So, this is a concern that has been expressed.

The Minister for Health and Social Services:

I understand that has been expressed by a number of people in different areas. But I go back to the point that it is not for ethicists to decide how somebody wants to treat their situation. I think a person with extensive disabilities has the right to determine for themselves. I make the point again, and I hope I have made my point clear, but I will do my best to make it again. We have had an ethical review. We have included that ethical review and the results and the recommendations in the ethical review for democratically elected people to take into account. Now, you might find 48 of those people saying: "Absolutely, I agree with that ethical review, and I will have no part in it." That is democracy. Or have I missed something?

Deputy L.M.C. Doublet:

No, that is helpful. So, we got one of your views there that you disagreed with the ethical review. This is what we are hoping to draw out in the hearing, is your personal political views, Minister, and why the decisions have been made or not made and what has gone into the report? This is a normal part of the scrutiny process.

The Minister for Health and Social Services:

I understand all of that.

Deputy C.D. Curtis:

Just to round this bit up, I am not sure. Lower perceptions of the quality of life of persons with disabilities are already commonly documented, so is there a plan put in place in terms of training in order to mitigate this, so that anyone involved in the process is not going to be thinking in this way?

The Minister for Health and Social Services:

If you look at the process, it is pretty comprehensive and it draws in people from all sorts of trained backgrounds. I have to say, I struggle to imagine how you could possibly have a process that is actually operable that could be more comprehensive than the proposals that we have.

Deputy C.D. Curtis:

You do not think there is needed any training to help mitigate this?

The Minister for Health and Social Services:

I have not said that I do not think there is any training, but I would refer to the fact that we are dealing with educated, qualified people, and a good mix of them that come into this whole process.

Deputy L.M.C. Doublet:

I wonder if the officer could state whether there is anything included in the training that might cover this area.

Director of Health Policy, Government of Jersey:

Absolutely, there will be. As set out in the proposals, there will be a detailed mandatory training programme that everybody who works in the Jersey assisted dying service will need to step through. If the States would determine that we should progress with route 2, that mandatory training programme will include a whole module relating to disability awareness, to ableism, to underlying concepts and prejudices that may exist in life values. In addition to that, as set out in the proposals, as well as mandatory training for people who are directly involved in the Jersey assisted dying service, the oversight committee that is going to be established, the Minister will establish as part of H.C.S. (Health and Community Services) will have duties and responsibilities to provide guidance and to provide training to other health and care professionals who do not work in the assisted dying service, but who provide support and treatment and care to people who may request an assisted death. One of the things that we would look at, if route 2 was to go forward, is how to support additional awareness of ableist views being imposed on people with a disability and their quality of life. So, we would look at it from both angles, both those in the service and other healthcare professionals.

Deputy L.M.C. Doublet:

In terms of the ethical review, so the points raised about the ableist judgments about the negative value of lives of people with disabilities. We have covered that. There were some other concepts around the unbearable suffering route, and the ethical review raised the following points. That the concept of unbearable suffering was vague, multifaceted and subjective, and has that inherent subjectivity to it. Given those concerns raised, can you outline why the decision was ultimately made to continue with route 2.

The Minister for Health and Social Services:

I will come back to my original point. We live in a democracy. The previous Minister for Health and Social Services - one person - decided to call for an ethical review. Fine. We have an ethical review. They come up with a recommendation. It is the recommendation of 3 ethicists and that has been included for the Members of the Assembly to review and take a decision on that basis. If we rely on

ethical reviews, why have we gone through this process? Why did we not have an ethical review for the whole thing and take the opinion of 3 people and rest with that opinion? I would ask you how you would feel if I would have come along and said: "I am either removing it or altered the process that the States originally intended." Basically, we have gone through a complex process, and I am presenting that as is.

Deputy L.M.C. Doublet:

Just to clarify the answer you have given. Did you disregard the ethical review in your decision-making process?

The Minister for Health and Social Services:

I am not sure how I would have done that. I have taken full account of the ethical review, and it has been included for the elected Members to make of it what they will. I cannot see any evidence of disregarding anything. I accept that there has been an ethical review. I accept that they have reached their conclusions, and it is not for me to decide what the other 48 Members decide upon. I have presented that for them because I believe that that is the democratic process. I imagine you would be very critical of me had I done otherwise.

Deputy L.M.C. Doublet:

Not getting to the debate just yet, so focusing on the period of time between the ethical review and the proposals that have been lodged, in terms of the decision making between then, what regard did you give to the ethical review before you lodged these proposals?

The Minister for Health and Social Services:

It is something that came up. I am in danger of repeating myself horribly. I looked at the ethical review and I thought, there we are. We have had the opinion of 3 ethicists, and I think it is appropriate that that should be included in the proposals that go forward for the States Members to decide for themselves what they make of it.

Deputy L.M.C. Doublet:

The points that they made about the concept of unbearable suffering being vague, subjective and multifaceted; what are your views on those points that they raised?

The Minister for Health and Social Services:

I do not particularly agree with them. I think this is a matter of personal individual choice, and somebody should not have a decision made for them because they become disabled.

Deputy L.M.C. Doublet:

Thank you for giving your view.

The Minister for Health and Social Services:

I think people have a fundamental right, come what may. Because if I become disabled, and that may well happen, I would find it patronising if somebody else came along and said: "You cannot have access to this because I have decided for you." I will be very, very clear; it is about personal rights. I hope that is clear.

Deputy L.M.C. Doublet:

That is very helpful. That is the kind of answer that I am looking for in terms of the philosophy.

The Minister for Health and Social Services:

Sorry if it took me a while to get there.

Deputy L.M.C. Doublet:

It is okay, we got there.

The Minister for Health and Social Services:

I am very happy to say that.

Deputy L.M.C. Doublet:

In terms of the inclusion of route 2, what are the main risks in including route 2, and how do you intend to mitigate them?

The Minister for Health and Social Services:

If you look at the required process, it is more elaborate than for route one because it has all the requirements of route one, plus a tribunal and a longer timeframe. Like I say, having witnessed the amount of work that has gone into this, I think it would be difficult to come up with something even more comprehensive and yet still have it workable.

Deputy C.D. Curtis:

Can you comment on the concerns raised about the potential for the expansion of assisted dying in numbers and scope, and how they specifically will be mitigated?

The Minister for Health and Social Services:

Is this a reference to what other people tend to refer to as the slippery slope?

Deputy C.D. Curtis:

I think so, yes.

The Minister for Health and Social Services:

I think in all the time that I have had an interest in assisted dying, I have had people mentioning the slippery slope this and the slippery slope that. All I would say is whatever rules and regulations may come about, whatever laws come about as a result of this process, to have any changes to those laws would require precisely the same degree of care and attention that this has received. Within the provisions that will come through from this, if they do come through, I do not see there is any route for slippage. The only slippage that can occur is if somebody goes back to the Assembly and asks for changes, and those changes would have to go through the same rigorous process as we have already been through. I personally find it something of a false argument.

Deputy C.D. Curtis:

Because I understand that this cannot be amended with regulations, it has to come back as another law.

Director of Health Policy, Government of Jersey:

Very specifically, the proposals do not allow for any regulation-making power. Every decision must come back to the States Assembly. It might also be helpful for the panel to understand that in some of the jurisdictions where there has been an expansion of the eligibility criteria over a period of time, that has sometimes been driven by the fact that other jurisdictions have hardwired into their legislation a 5-year review period.

[12:00]

It is that review period and the outcome of that review period, which has resulted in an expansion of criteria. This legislation very deliberately does not do that.

Deputy L.M.C. Doublet:

That is interesting. Could you speak some more about that, about the review period and was that considered, and obviously it was disregarded and why was it disregarded? Are there any other factors that were considered?

The Minister for Health and Social Services:

You will have the details of that.

Director of Health Policy, Government of Jersey:

We have done a lot of thinking around this issue in developing proposals; a lot of thinking around the issue of the slippery slope. We have been very live to the concerns that have been expressed to us by members of the public, and also very live to the fact that in some jurisdictions - not all jurisdictions - where assisted dying has been introduced, you have seen an incremental expansion of the eligibility criteria. When, as officers, we were set out on this task, one of the guiding principles was you need to address to look at how your proposals address the slippery slope. For that reason, as I said, we have not included regulation-making powers. I think it was in Canada and one other jurisdiction - I am sorry, I cannot remember which jurisdiction - they included this review period. But the other thing that we have done is we have looked at the reasons why you see an expansion of criteria in other jurisdictions. Sometimes that is because those jurisdictions have made a decision … Parliaments of those decisions, have made a decision looking at the day-to-day working of their assisted dying legislation that needs to be amended. But in some jurisdictions, there is a very different reason. Canada is often cited as the jurisdiction of concern. One of the things that is not necessarily understood about the experience that they have gone through in Canada is that, in Canada, they essentially have a Bill of Rights, which has a right in it, which is a right to die. We do not have that in the European Convention for Human Rights. What has happened is individual members of society have gone to the courts in Canada and have argued for their right to an assisted death and argued that their legislation in Canada was too restrictive because it provided an assisted death for some people and not other people. Because of their Bill of Rights, their court has agreed with them. Also in Canada, the way that their legislative system is set up is very different. Essentially, their Supreme Court can now instruct their Parliament to amend its legislation. It is a very, very different set up.

Deputy L.M.C. Doublet:

Those risks do not exist in our set up?

Director of Health Policy, Government of Jersey:

They just do not exist. The European Convention on Human Rights is absolutely silent on the right to die. There is no right to die. There is no point at which a person can argue under the European Convention on Human Rights, that they have a right to assisted death. They do not. They have a right not to be discriminated against, but they do not have a right to die for an assisted death.

Deputy L.M.C. Doublet:

Minister, are you satisfied that any risks of this slippery slope happening, that any risks have been avoided or mitigated?

The Minister for Health and Social Services:

Absolutely, yes

Deputy L.M.C. Doublet:

Before we move on, in terms of the route to unbearable suffering, are there any other factors that you would like to highlight that influenced your decision to include that in the proposals?

The Minister for Health and Social Services:

Nothing that I have not mentioned already.

Deputy L.M.C. Doublet:

We are going to move on to another aspect that was highlighted in the ethical review and your proposals have been brought forward in line with the ethical review; that is the age of 18 and over. The decision was made to restrict the assisted dying service to people over the age of 18. This proposed eligibility criteria, is it in line with other jurisdictions and did you receive any views during the consultation period that argued the other way to reduce that age?

The Minister for Health and Social Services:

In terms of the detail of the consultation that was received, I would have to hand that over to Ruth.

Director of Health Policy, Government of Jersey:

When the States made the original in-principle decision in 2021, they made the in-principle decision for 18 and over because that was recommendations of the citizens' jury. However, within the body of that report, for that report and proposition, we said that we would do additional consultation on this issue. We reached out to the then Children's Commissioner to have a conversation about how we manage the consultation with children and young people on such a sensitive subject, and we got a very clear steer back from the Children's Commissioner that it was the view of the Children's Commissioner that this subject was potentially so distressing to children and young people that the benefits of consulting them were outweighed by the risks of consulting them. What we did not do is bespoke consultation with children and young people. However, we had young people who did attend some of our public hearings, and those young people held different views on whether or not children should be eligible to assisted dying.

Deputy L.M.C. Doublet:

Can you advise what age they were?

Director of Health Policy, Government of Jersey:

When we have gone to public consultations, we do not ask them to give their age. But I am guessing that they were older teens, early 20s. From about the age of 18 to 22, 23; around that kind of age range. They held a mixture of views. The key issue that was expressed by the younger cohort of

people who came to our public hearings was not about whether or not children should be allowed to have an assisted death. They were very focused on the principle of assisted dying for older people. An awful lot of that was shaped by their own personal experiences where they had lost parents or they had lost grandparents, rather than engaging with the issue of under-18s. We did, however, in the survey that we did alongside the public meetings, have feedback on this issue. As with much with assisted dying, there was no clear consensus because there are a lot of polarised views about it. The majority of people who responded to the survey felt that it should only be available to people over the age of 18 because they were concerned about the issue of competency to make that decision. Also, there was a concern about conflict between parent and children's relationships. If the child wanted an assisted death and the parent did not, what could be the consequences of that on those last few months, potentially, of that child's life? There is no easy or obvious answer to this one. It is one of those really difficult nuggety policy issues, which a decision will just need to be taken on. It is perhaps helpful to note that no other jurisdiction, apart from Belgium and Netherlands, permit assisted dying for under-18s. The Scottish proposals that just came out talk about 16-plus but there are no other jurisdictions at the moment that currently permit it for under-18s. In Belgium and Netherlands there are lots of restrictions and caveats associated with it.

Deputy L.M.C. Doublet:
That background is really helpful. Thank you. You mentioned that it was a difficult ethical question. Minister, we would like to try and understand your philosophy and your views behind that. Can I just check that everybody understands what Gillick competency is? Could you explain, please?

Director of Health Policy, Government of Jersey:
Gillick competency is a test that is undertaken not just by healthcare professionals, but also often by lawyers and social workers, to understand what the competency of a child is to make a decision, because obviously different children mature at different ages. You may get some 15-year-old who would be, under the Gillick test, considered to be highly competent to make highly difficult decisions. Whereas you will get some older children who will be assessed as having lower competency because of their ability to understand, retain and process complex information.

Deputy L.M.C. Doublet:
So, a judgment based not necessarily on their chronological age, but on the competency of their decision making?

Director of Health Policy, Government of Jersey:
Yes.

Deputy L.M.C. Doublet:

Minister, with this concept in mind, could you outline why proposals were not included for under-18s who could demonstrate this Gillick competency to be able to access assisted dying?

The Minister for Health and Social Services:

If I am quite honest, I think Jersey has already taken a fairly major step in both (a) and (b). There is certainly not sufficient experience in any of this to be going into an area which is, as you describe it, Ruth, complicated. You used 2 terms that I thought were …

Deputy L.M.C. Doublet:

Very difficult ethical area.

The Minister for Health and Social Services:

Absolutely. This really is a very tricky area. I have to say, if I was 16½, 17 and confronting a terminal illness and was in acute pain, I would feel aggrieved that the law did not include me. But I think we have to have a sensible starting point. I think the one that we have is probably as far as it was sensible to go at this stage.

Deputy L.M.C. Doublet:

Thank you. Is it fair to say, if there are areas that might be revisited down the line, that this might be one of them?

The Minister for Health and Social Services:

There are 2 key areas that are difficult: mental illness and below 18. Those are 2 very complex areas that may, at some point in time, come back on to the radar for further consideration.

Deputy L.M.C. Doublet:

Thank you for sharing your views on that.

Deputy C.D. Curtis:

I have a question next about the consultation. I think it is ongoing or about to start with disabled people. Minister, the panel understands that targeted engagement sessions with disabled Islanders will be undertaken with Enable Jersey, Acorn and the Jersey Employment Trust. Please give us some details of what this engagement will entail.

The Minister for Health and Social Services:

I do not know what the actual engagement itself will be, but I very much support that process because I do not think it is fair … if people are feeling vulnerable, then I think they need to have special consideration. But in terms of the actual process, I would have to leave that to you, Ruth.

Director of Health Policy, Government of Jersey:

We have already undertaken engagement with disabled Islanders, because many disabled Islanders or some disabled Islanders came to our public meetings, but also, we undertook targeted engagement working with Enable Jersey as part of our phase 2 consultation. But at that point in time, we were talking to disabled Islanders around everything to do with assisted dying. That included route 2 but was not focused just on route 2. So, a commitment was made in response to the recommendations of the ethical review that we did further targeted engagement with disabled Islanders, very specifically on route 2. We are working on developing an engagement script with those organisations at the moment, which we will step through. That is not available yet, but we can certainly share it with the panel when it is. But the focus will be looking on those critical key issues that you have already raised around what does ableism look like within this. If route 2 is to go forward, what do you think about that and also what do you think the necessary protection should be to support you as disabled people who, as we know, are sometimes, unfortunately, dismissed by society. It will be very much focused on that conversation there. It might also be helpful for the panel to understand that, as I mentioned, we did consult disabled people in phase 2 consultation. As with all groups of people, disabled people hold different views on assisted dying, including on route 2.

Deputy C.D. Curtis:

Thank you for that. Do you have an idea of what proportion of Islanders with a disability are going to take part in this later consultation?

Director of Health Policy, Government of Jersey:

Not yet. It is all being worked out with Enable and Acorn at the moment.

Deputy C.D. Curtis:

Do you know what types of disabilities are included in the consultation to get a broad view of everyone's …

[12:15]

Director of Health Policy, Government of Jersey:

We are working with them to make sure that we cover people with learning disabilities, people with physical disabilities, people with sensory disabilities. You may be aware that as part of the previous rounds of consultation, we have done sign language videos to explain. Not all the proposals because that would be impossible to do, but to explain what it is that we are looking at doing, and

we have done easy-read versions. We have done quite a lot of work to try and proactively reach out to people who will have a different view on these proposals.

Deputy L.M.C. Doublet:

I wanted to understand in terms of the timeline, because obviously there is a shortened timeline for these proposals being debated. The consultation is happening, and I think at the end of April will be concluded, and the debate date is 21st May. I would like to understand how that consultation is going to be meaningful in terms of having an impact. Could you outline what you will do with the information that you glean from that consultation?

The Minister for Health and Social Services:

Once again, it is not me that is going to be compiling that. That will be Ruth. If you just go through the process, Ruth, because, as I say, it is a detailed process. That is beyond my remit.

Director of Health Policy, Government of Jersey:

What we will be doing is we will be producing a feedback report, a bit like the feedback reports that we have done for other consultations, and it will be published. It will be a matter of public record. It will be published also as an addendum to the report and proposition 2 weeks before the debate. It will reflect back what people who participated in those consultations said to us around route 2, what they believed the implications for route 2 are on them and their lives and their decisions and, if route 2 is going to go ahead, what they think should be provided for to protect them.

Deputy L.M.C. Doublet:

Thank you. Minister, if disabled Islanders conclude that they do not agree with the unbearable suffering route being included in the proposals, what action would you then take?

The Minister for Health and Social Services:

I think I would have to wait and see what the nature of that decision was and what comes from that consultation process.

Deputy L.M.C. Doublet:

This is a hypothetical. If the conclusion from the disabled community that the unbearable suffering route was not acceptable to them, would you change any of your proposals? Would you make any late amendments?

The Minister for Health and Social Services:

Given that it is a hypothetical question, I am afraid I am going to reserve my position on that. I shall take a very close interest in that information when it comes through, and I am very happy to tell you what my thoughts are when it does.

Deputy L.M.C. Doublet:

Okay. Perhaps moving from any specific outcomes, are you minded to make any late amendments at that date to take into account anything that is ...

The Minister for Health and Social Services:

If something substantial and vitally important were to turn up, then that would have to be under consideration. At the moment, I am not really expecting it. As Ruth has said, being disabled is being disabled. It does not prevent a person from having the same views pre-disability as post-disability and I think we need to let those people speak for themselves.

Deputy C.D. Curtis:

I just wanted to add, I think it will be interesting to see as well from this consultation that the disabled people who want to have the right to assisted dying are not denied it for any reason.

The Minister for Health and Social Services:

That, I think, is an important point.

Deputy L.M.C. Doublet:

Okay, thank you. I would like to ask about the multidisciplinary teams and the associated assessment guidance. The multidisciplinary teams will be formed but the requirement in practice of those teams will not be provided for within the actual legislation. Could you just provide information to us about why that will not be in the legislation given that a team will be formed for each of the assisted dying requests?

The Minister for Health and Social Services:

I am aware of the formation of the teams, but I am not sure as to why that is not included in those requirements. Ruth, if you can ...

Director of Health Policy, Government of Jersey:

Yes, the law said there would be a multidisciplinary team that will place a duty on the Minister to ensure that there is a multidisciplinary team available. The reasons why the actual work and activities will not be described in detail in the legislation is because it will be entirely dependent on the person who has made a request for an assisted dying. For example, if there are concerns about potential coercion, you will need to engage different members of the multidisciplinary team with

different skills, for example more social workers who have more understanding and training in family dynamics to look at the coercion issue. If the person who has made a request has a communication difficulty, you would need to engage the members of the multidisciplinary team who have speech and language therapy support. It is not defined because the activities of that team will be entirely dependent on the needs of the person who has made the request and on the requirements of both the co-ordinating doctor and the independent assessment doctor in terms of what extra skills, knowledge, et cetera, they need to be able to make a full assessment of that person and that person's situation.

Deputy L.M.C. Doublet:

Thank you. Minister, are you satisfied that we have the necessary expertise on-Island to form these teams to make good, robust decisions?

The Minister for Health and Social Services:

In general, to the extent that I know I would say yes, and I would have thought that if we really needed expertise from elsewhere, then we would seek that expertise from somewhere else, would we not?

Deputy L.M.C. Doublet:

Is it possible within the scope of the proposals to seek expertise from off-Island?

The Minister for Health and Social Services:

I would have thought so.

Director of Health Policy, Government of Jersey:

Yes, the proposals are very clear, and it is not just related to the multidisciplinary team. It is related to everybody who works in the assisted dying service because there is a right to refuse to participate. People need to opt in to work for the service, and that would include the members of the multidisciplinary team. It may be that we either cannot engage individuals with the right skills who are currently on-Island, or we cannot engage enough of the right people with the right skills on-Island. The proposals are very clear that in order to be able to stand up this service the Health Department may need to contract non-resident professionals to come to Jersey on a contract basis to support an assisted dying request, but it is really important to note that if we do that the proposals are very clear that that person must be registered with the Jersey assisted dying service. They must have undergone the mandatory training, and they must meet the competency requirements for that particular post.

Deputy L.M.C. Doublet:

Thank you. One concept I would like to focus in on, which I think Ruth raised, is that of coercion. I understand that there are concerns among members of the public, and it was also raised during the previous States debate, around individuals being coerced into opting for assisted dying. Indeed, since that debate, we have also had the V.A.W.G. (Violence Against Women and Girls) taskforce report, which found that among support services on-Island there was an alarmingly low rate of understanding of what coercion looks like. How can you be certain, Minister, that the multidisciplinary team will be equipped to spot coercion where it does take place?

The Minister for Health and Social Services:

Well, as Ruth has suggested, some of those people will be people that specifically are trained, will have experience in monitoring and identifying coercion. Given that you have got an initial doctor, a secondary doctor and a multidisciplinary team available to them, I would make the point that I am not quite sure how much further you can go to establishing where coercion might exist. My understanding from some of the empirical evidence that I have had is that coercion very often relates more to people being coerced into not taking an assisted death than to actually taking their life.

Deputy L.M.C. Doublet:

Do you share the concerns of members of the public and States Members that there is a risk that coercion to accepting or to accessing assisted dying might happen?

The Minister for Health and Social Services:

There is always a possibility but given the complexity of the process, I think it is highly unlikely and I think we do have ... I am very satisfied that those safeguards should be sufficient.

Deputy L.M.C. Doublet:

What evidence are you using to base the assertion that coercion is unlikely?

The Minister for Health and Social Services:

My understanding is that in other jurisdictions ... I became quite friendly with the principal director of Dignitas and had a number of conversations with him. He said that he had been involved in 300-and-something assisted deaths and he had not come across coercion in that time.

Deputy L.M.C. Doublet:

Given the findings from other reports that there is a very limited understanding of coercion among support services, do you think the perception that there is not much coercion happening is an accurate perception or do you think perhaps there might be more there that is undetected in our community?

The Minister for Health and Social Services:

I have to say if there is it is not apparent to me, but Ruth has done much more consultation than I have and read up a lot more than me. Ruth might want to make a comment on that. It would be a lot more of a qualified opinion than mine.

Deputy L.M.C. Doublet:

I would like to ask that could you take a look at that concept and take a look back at perhaps the V.A.W.G. taskforce report and expert views on coercion and ensure that it is included in the training in a robust way so that those professionals are equipped to spot it.

The Minister for Health and Social Services:

I am happy to. Yes, that is fine.

Director of Health Policy, Government of Jersey:

There would be a dedicated module around coercion within training, which everybody would undergo. I think the ...

Deputy L.M.C. Doublet:

Can I just stop you there? Could you point to where it would be? On page 241 of the proposals, in appendix 4, which outlines the training, I may have missed it, but I am struggling to find the specific area.

Director of Health Policy, Government of Jersey:

Let me just do a search and find. While I do that search and find, I think the other thing that it might be helpful to understand is that the law will provide a very specific duty on both the co-ordinating doctor and the independent assessing doctor with regard to coercion. The law says that they must be satisfied to the best of their ability that there is no coercion. It is not that they can approve it if there is a lack of evidence of coercion, so it is the other way round. They must be satisfied. If they have got any doubts that there is potential coercion, even if they cannot evidence that there is coercion, they cannot approve the request for an assisted death.

Deputy L.M.C. Doublet:

Given that it does not seem to be highlighted as a specific area of the training, Minister, would you agree to take a look at the format of that training to ensure that it is included in sufficient detail?

The Minister for Health and Social Services:

I will certainly take a look at it, but I will make the point again that in any of these proposals one has to eventually exercise some common sense and make a judgment as to looking at those proposals,

looking at the safeguards and saying on balance, is that a sensible way to proceed. I am comfortable at this point in time that it is, but I will take up your point.

Deputy C.D. Curtis:

The panel notes that each assisted dying tribunal will be appointed by the Bailiff and consist of one legal member, one medical member and one lay member. Please can you provide more information about the level of experience required of the medical member of the tribunal?

The Minister for Health and Social Services:

To be honest, I am not familiar with that process. Ruth, would you be able to help with that?

Director of Health Policy, Government of Jersey:

The tribunal would be stood up through the Royal Court, and that would be a decision for the Royal Court to stand up as part of the tribunal service. Clearly there have been active and live conversations about the skillset that is required but it would be a determination of the tribunal service as to the level of experience that they would require. I have no doubt that they would seek advice on that.

Deputy C.D. Curtis:

So, there is not anything set in stone about the level of experience, because I think there was some discussion around perhaps that the medical person should be someone with quite a lot of knowledge and experience over the years.

Director of Health Policy, Government of Jersey:

You will understand that I cannot speak for the tribunal service, but I have got absolutely no doubt that they would seek to secure tribunal members who have demonstrable high-level experience within their field, given the sorts of decisions that they will be required to make.

Deputy C.D. Curtis:

For the actual administering practitioner, they have to be a level 1 experienced medical person, so the tribunal does not have any requirements?

[12:30]

Director of Health Policy, Government of Jersey:

Please excuse me if I have misunderstood the question, but what the proposals do is they set out at a very high level what the requirements will be for the people who are working in the service.

What the proposals do not do is detail what the requirements will be for the members of the tribunal because that is a decision that will be taken by the tribunal service.

Deputy C.D. Curtis:

That is what I am saying, really. Also, the tribunal will consist of a lay member, so it is the same, there are no requirements of a lay member of the tribunal apart from what the tribunal decides?

Director of Health Policy, Government of Jersey:

Yes. I have got absolutely no doubt that the tribunal service will develop those requirements at the point at which it was looking to stand up and recruit a tribunal.

Deputy L.M.C. Doublet:

I wonder if we should follow up those ones anyway, so the Bailiff ...

The Minister for Health and Social Services:

What we are saying currently is we put our trust in the tribunal service.

Deputy L.M.C. Doublet:

Yes, so the Minister does not have oversight of that service.

Director of Health Policy, Government of Jersey:

No.

Deputy C.D. Curtis:

There are no guidelines or anything?

Director of Health Policy, Government of Jersey:

Yes.

Deputy C.D. Curtis:

Now a question about capacity. Minister, the panel notes that the ethical review recommended removing presumed capacity but that the final proposals include presumed capacity, so no capacity test when someone is applying. Please can you describe the consideration that was given to removing the presumption of capacity and why the decision was taken not to?

The Minister for Health and Social Services:

Sorry, could you repeat that very detailed question?

Deputy C.D. Curtis:

Okay. When someone is asking for an assisted death, it is taken for granted they have the capacity to make that decision. The ethical review said that the person should be tested to make sure they have capacity at that time.

The Minister for Health and Social Services:

I did not realise that there is no capacity test. Is there no capacity test at all, Ruth?

Director of Health Policy, Government of Jersey:

It is a bit more complex than that. What the proposals say is that there will be a presumption of capacity but if there are any concerns about capacity that capacity must be tested, and that is absolutely standard with every other single piece of legislation. For example, our mental health and capacity law works on the premise that there is an assumption of capacity. What is set out in the proposals is entirely in accordance with Jersey legislation and is entirely in accordance with legislation within the U.K. (United Kingdom) about presumptions of capacity. There is nothing unusual about it, but even though there is a presumption that a person has capacity, there is a very clear legal duty placed on the co-ordinating doctor and the independent assessing doctor if there are any concerns, fleeting, glimpsing concerns, about capacity and if they are not fully qualified themselves, because some of those doctors will be qualified to make capacity assumptions, they must - and it is a requirement of the law - go and seek a specialist who can undertake a capacity assumption. In addition to that, as set out in the proposals, it is envisaged that what the law will provide for is a capacity test against which a person's capacity will be tested, which is very specific to assisted dying and goes beyond the capacity test which is currently set out in the capacity law. There is a belt and braces approach within that.

Deputy L.M.C. Doublet:

Minister, did you consider a compulsory capacity test as part of the proposals?

The Minister for Health and Social Services:

No.

Deputy L.M.C. Doublet:

Why did you not give consideration to that element, given it was advised by the ethical review?

The Minister for Health and Social Services:

I am sorry, I just simply cannot answer that. Once again, it is a very specific question and bearing in mind I have had a relatively limited amount of time to apply myself to this, I trust a lot to what Ruth

does. I think Ruth has given a very adequate explanation of the situation in any event, which hopefully you are happy with.

Deputy C.D. Curtis:

Can I ask as well then, in other jurisdictions is there no capacity test done in the same way as what is done for Jersey?

Director of Health Policy, Government of Jersey:

A few things within that. In terms of other jurisdictions, every other jurisdiction that permits assisted dying requires capacity. The law in those other jurisdictions takes a different approach to whether or not they have a specific capacity test or not, and this is often the case with assisted dying. In other jurisdictions there are very different approaches to it, but the presumption of capacity is a common feature in lots of other assisted dying laws. This particular recommendation of the ethical committee was, I think, of all the recommendations that they made the one that we found to be slightly unusual, one of the reasons being that it is a basic human right to assume that a person has capacity until it is proved that they have not, akin potentially to it is a basic human right to assume a person is innocent.

Deputy L.M.C. Doublet:

Do you agree with that analysis, Minister?

The Minister for Health and Social Services:

Absolutely, yes. I am glad that Ruth has been able to explain it so comprehensively. I hope you are happy with that as an explanation.

Director of Health Policy, Government of Jersey:

But related to that, I just thought it might be helpful to understand, because it goes back to some of the earlier questions about route 2, the process in terms of making the decisions in the proposals that have been put forward to the States Assembly. Before Deputy Binet was appointed as Minister for Health and Social Services, there was a Ministerial working group on assisted dying, which included the Minister for Home Affairs, the Minister for Health and Social Services and the Minister for Social Security because they have a portfolio interest in assisted dying, for want of a better description. It has just been a matter of timing. It was those Ministers who made some of the detailed decisions around how we progress with capacity and around the inclusion of route 2 on the basis, and only on this basis, that it was in the original report, it was in the original in-principle decision.

Deputy L.M.C. Doublet:

Thank you for explaining some of the political decision-making behind that. Minister, given your officer has outlined some of the wider political accountability around this, have you significantly varied from any of the decisions of that group in the proposals that you have brought forward?

The Minister for Health and Social Services:

No. As you will have gleaned from what has been said, I have not had the benefit of participating in the 18 months of work or 2 years of work of any of those bodies coming up to this point in time. In real terms, I have come to the party very, very late, so my intervention in all of this has been relatively low, simply because I have not got the benefit of having had inclusion in all of those processes.

Director of Health Policy, Government of Jersey:

For the purposes of clarity, there was one outstanding decision on what went in the proposals that was made after Deputy Binet was appointed as Minister for Health and Social Services. Everything else had been made beforehand and that one outstanding decision was in the case of route 1 where it says that the minimum timeframe is 14 days. It was clarified to say unless your life expectancy is less than 14 days when there is no minimum timeframe. That was a live issue that had not been resolved before Deputy Binet became Minister, and that is the one policy issue that has been resolved by Deputy Binet since he was appointed Minister for Health and Social Services.

Deputy L.M.C. Doublet:

That is helpful, thank you. Minister, have you read and understood and analysed all of the associated documents that would have been considered by that group in order to reach the agreement ...

The Minister for Health and Social Services:

Not all of them, no, I have not.

Deputy L.M.C. Doublet:

Which ones have you read and which ones ...

The Minister for Health and Social Services:

I have not got a list. If I showed you the pile of documentation that I have been presented with over the last 8 weeks, I would have to take a month off to get through it all. I have had to get through whatever documentation I have been able to put my hands on that I think is relevant to the requirements of the moment, if that makes sense. I simply would have no chance of having gone through all the documentation from all of the past. It just would not have happened.

Deputy L.M.C. Doublet:

In terms of the area of assisted dying, which documents do you have a thorough understanding of?

The Minister for Health and Social Services:

I have not brought a list with me. You have to forgive me.

Deputy C.D. Curtis:

You have mentioned about the training around capacity and so on already. I have a couple of questions now, which are about the continuation of palliative care. Once someone is in the assisted dying process, can you advise what support will be provided for healthcare practitioners so that they can continue with the good palliative care until the end of life? Also, can you confirm whether any palliative care is only stopped at the point of administration of the assisted dying substance?

Director of Health Policy, Government of Jersey:

Yes. The proposals set out - and this was one of the key underlying principles that are listed in the front of the proposals - that assisted dying is not an alternative for end of life or palliative care. It is an additional choice that some people may choose to make. It is the case that the majority of people who request an assisted death will be in receipt of end of life or palliative care. There is lots of evidence that that is the case in other jurisdictions. That end of life and palliative care will continue through the whole of the assessment process and will continue up until the point that if the request is approved the substance that brings about death is administered. So, there is no disruption to that palliative care and end of life treatment. It is not as if they are making an assisted dying request and then they are being diverted down another care route. They are still actively receiving end of life and palliative care. One of the things that it might be helpful to understand is that a person's request for an assisted dying is a private matter. It may be that that person wishes their palliative and end-of-life care team to know about their request. It may be that they do not wish that, and that information would not be disclosed to the end-of-life or palliative care team without the person's permission or without an in-depth conversation with the person if there was any potential risks associated with the provision of care with not disclosing that information. That is how we will ensure or work to ensure ongoing provision of end of life and palliative care. The other thing, as set out in the proposals, is that the professionals who are caring for people, understandably because this is part of their job, often become very invested in that person and can find it distressing if that person wishes to have an assisted death. So, the proposals set out, and there is provision made for it in the financial resource implications, not only to provide counselling and support to professionals directly involved in the assisted dying service but also in what we call the other associated care professionals who will be providing day-to-day care for that person.

Deputy L.M.C. Doublet:

I am just noting the time that we have left, and we still have a number of questions, so if answers could be shortened slightly and we can always ask for more detail in writing. Minister, I would like to ask you about the concept of the waiver of final confirmation of consent. How will signs of refusal or resistance be established if a person has been deemed to have lost their decision-making capacity?

The Minister for Health and Social Services:
That is another technical question that I think I will have to ask you to help with, Ruth.

[12:45]

Director of Health Policy, Government of Jersey:
We have had conversations with healthcare providers about this. If a person was not consenting, the signs of consenting would be things like them turning their head away or shaking their head or saying no or holding up their hands. There are both verbal and non-verbal cues that the administering practitioner would be trained to recognise.

Deputy L.M.C. Doublet:
That was going to be my next question. Will that training be mandatory?

Director of Health Policy, Government of Jersey:
It will be, yes. All the training associated with this will be mandatory.

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

Deputy C.D. Curtis:
The ethical review recommended that professional guidance is developed to ensure that adequate efforts are made to ensure that assisted dying is a last resort. Please can you confirm whether the guidance developed in relation to assisted dying covers this aspect?

Director of Health Policy, Government of Jersey:
It absolutely does. Within the assessment process, both for the co-ordinating doctor and the independent assessing doctor, it is very clear that any decision to have an assisted death must be informed. Informed includes placing a duty on those doctors to make sure the person knows about and is informed about alternative care and provision treatments for them so that there is absolutely no presumption that an assisted death is the right way forward for the person.

Deputy C.D. Curtis:

They see what treatment is available in case they are not getting it at the moment?

Director of Health Policy, Government of Jersey:

Yes.

Deputy C.D. Curtis:

We could not see it in the forms and guidance section.

Director of Health Policy, Government of Jersey:

Apologies if it is not clear in that or if it is an oversight. That is all it will be. They are quite dense at this stage, as I am sure you will appreciate. As we come to the full development process, if there are any oversights or gaps, those will be picked up.

Deputy L.M.C. Doublet:

In terms of that appendix 3, the forms and guidance, are there likely to be additional forms and additional guidance documents that would be added to that?

Director of Health Policy, Government of Jersey:

Absolutely. As a policy office, it has been quite difficult for us. We have tried as much as possible to bring forward as much detail as possible but to a certain extent, until the States Assembly have made decisions as to how they want to progress, it is a bit of a moving target.

Deputy L.M.C. Doublet:

In terms of that list of guidance, the ethical review recommended that some guidance was produced to mitigate against confusion between the 2 routes. Can you confirm whether that guidance has been developed, because we could not spot that in the list?

The Minister for Health and Social Services:

I have to defer to you, Ruth.

Director of Health Policy, Government of Jersey:

It has not been developed but it will be developed. There will be very clear guidance on what route 1 and what route 2 is.

Deputy L.M.C. Doublet:

Okay, thank you.

Deputy C.D. Curtis:

Will this be in place before it comes back to the Assembly then, so we are able to see it?

Director of Health Policy, Government of Jersey:

What will come back to the Assembly is the draft law. I think that if the Assembly was to want all the guidance in place at the same point that the draft law is in place, that will potentially create some delays in getting the draft law forward to the Assembly. Also, there are very real practical difficulties in writing guidance against the draft law. It needs to be in approval because if the Assembly were to make any amendments to the draft law, that would negate the guidance.

Deputy L.M.C. Doublet:

How will you manage that, Minister, in terms of giving States Members enough information as to what the guidance will be in terms of what Ruth has said?

The Minister for Health and Social Services:

I have to say I will simply trust Ruth as somebody I know who has put in an enormous amount and, as you can see, has a huge amount of detailed knowledge of this. There does come a point from a Ministerial point of view where you have to be reliant on your officers. I have to say I have a great deal of faith in what Ruth is telling us, so I am very comfortable with that.

Deputy L.M.C. Doublet:

Yes, I think you are lucky to have Ruth working on this policy area.

The Minister for Health and Social Services:

Yes, absolutely.

Deputy C.D. Curtis:

Could you provide examples of the appropriate means of communication that will be acknowledged if a person cannot verbalise a request to withdraw? I think you have mentioned some of them already, so is there anything to add to that?

Director of Health Policy, Government of Jersey:

Is this just about the withdrawal of the request or is it about the whole assessment process?

Deputy C.D. Curtis:

This is about them withdrawing. They would have already agreed and then they do not want it.

Director of Health Policy, Government of Jersey:

There would be verbal communication but also those non-verbals, as I have mentioned, the shaking of the head, the holding up of the hands.

Deputy L.M.C. Doublet:
So, it does not have to be in writing?

Director of Health Policy, Government of Jersey:
No, absolutely it does not need to be in writing.

Deputy C.D. Curtis:
That will be included in the mandatory training programme?

Director of Health Policy, Government of Jersey:
Yes, absolutely.

Deputy L.M.C. Doublet:
In terms of the training programme, we have asked some questions about that, and I think it is quite critical in terms of giving reassurance to States Members. Can you clarify when the detail on that training programme will be available to States Members, please?

The Minister for Health and Social Services:
In terms of timeline, once again I am reliant on you, Ruth.

Director of Health Policy, Government of Jersey:
Obviously, we have not started to develop it yet because there are some really big policy questions that need to be asked and answered. We have had some very preliminary conversations with some of the professional oversight bodies in the U.K. who develop clinical training about whether or not they would be interested in being commissioned to do this work. We have had some provisional indications that they would be. We would obviously look to lots of other jurisdictions, so New Zealand and Australia have got these really detailed training programmes. We have already got some indication that they would be prepared to share the detail of their training programmes with us. So, we would not necessarily be starting from a blank piece of paper but clearly whatever we are training would have to be Jersey-specific because it would be specific on our law. I would anticipate that if a draft law was brought forward, while it might not have all the detail of guidance, what it would do is it would contain a very detailed summary of what the training programme would look like, how it would work, what the modules would be.

Deputy L.M.C. Doublet:

Great, thank you. Minister, is this something that you will be ensuring that that happens?

The Minister for Health and Social Services:

I liaise with Ruth as much as I can on all of this so, yes.

Deputy L.M.C. Doublet:

Thank you. In terms of the assurance and delivery committee, the panel notes that this committee would publish an annual assisted dying report. One of the concerns flagged was that in some cases that could result in the identification of an individual, given the small size of our Island, and that a decision in that case may be made not to publish some demographic details to protect that anonymity. Please could you provide some more information about how the decision would be made of whether to publish or not to publish?

The Minister for Health and Social Services:

Once again, a highly detailed question that I have to refer to Ruth. A lot of these questions, I have to say, are extremely detailed. As you note from some of it, some of the decisions have yet to be made, so I am not party to that.

Deputy L.M.C. Doublet:

My approach is always a thorough one and will continue to be so.

The Minister for Health and Social Services:

I can see that, yes.

Director of Health Policy, Government of Jersey:

The first thing that we would do, and this is set out in the proposals, the director of Public Health would be acting in an advisory capacity as to the information that should be put out into the public domain. It is also important to recognise that there is a tension. To be transparent about the tension that exists with regard to information being in the public domain about an assisted death, part of that is that we would not, through that annual report, want to disclose information that may reveal the identity of a person or reveal too much about the identity of a person, because that is about respecting privacy. At the same time, it is really important to recognise that the death registration process for someone who has an assisted death will in fact put into the public domain the fact that that person has had an assisted death. When a death is registered - and this applies to all deaths - it has to be independently verified. There is a medical fact and causes of death certificate, which is completed by an independent doctor. The medical fact and causes of death certificate lists the cause of death and the ancillary cause of death.

Deputy L.M.C. Doublet:

That is available to every member of the public?

Director of Health Policy, Government of Jersey:

What happens with that certificate is the information is taken off it and it is put in the records of death, which are public documents. What that certificate will do - and this is just an example - it will say the final cause of death was cardiac arrest or asphyxiation and the ancillary cause of death, one of the factors to that cardiac arrest or that asphyxiation was whatever the name of the substance was or the fact that there had been a substance administered. It will not actually say there was an assisted death but if someone wished to, they could find that information within the public domain, so therefore they could find out that that person had had an assisted death. This was a subject of a lot of consideration as to whether or not this information should or should not be in the public domain. Different jurisdictions take different approaches to it. In some jurisdictions they just put the fact that the person had cancer. They do not put any information into the public domain that talks about an assisted death. There are genuine concerns about transparency and openness around that in what is a service that rightly should have a great deal of public scrutiny but also there is concern that if Jersey, like some other jurisdictions, is going to permit assisted deaths, you need to destigmatise that choice that people make. It needs to be a genuine choice that people do not feel fear or feel that they are going to be ridiculed or dismissed making. One of the ways in which you destigmatise things is you talk about it, and you are open about it. So, there is a tension between those 2 things.

Deputy L.M.C. Doublet:

Thank you. Minister, do you agree, or do you have any comments on the rationale there?

The Minister for Health and Social Services:

I am very comfortable with that, yes.

Deputy C.D. Curtis:

Just a couple of questions about the administering practitioners, and we did touch on this before around the tribunal. Practitioners with direct involvement in assisted dying will be level 1 doctors or registered nurses. Please can you confirm the level of experience in years required for them to undertake this role? Also, there was a lot of feedback and consultation that newly qualified doctors would not be appropriate, so if you could provide some response to that.

Director of Health Policy, Government of Jersey:

Yes, I can do except for the fact, I am really sorry, the detail has slipped my mind.

Deputy L.M.C. Doublet:

We could come back to it. There is another area that might take us a while to get into. We can come back to that and if we do not have time we will follow up in writing, I think. One of the principles within the proposals is the right to object to the provision of an assisted death. In terms of private landlords, can you provide some more information about the processes that might be followed by an administering practitioner if the patient is in shared accommodation and the owner of that accommodation objects to them having an assisted death?

The Minister for Health and Social Services:

To be fair, these are points of absolute detail. I have not been part of the 2-year process. It is very specific. Are you able to answer that, Ruth? It seems very specific to me.

Director of Health Policy, Government of Jersey:

Yes. It is proposed that the right not to participate is extended to premises owners. In most cases we would envisage that being a care home provider, so where a person is in a care home as a resident in care and has requested an assisted death, that care home provider may object for a whole range of reasons about the impact on other residents, et cetera. Clearly it is the case that where people live in some form of shared accommodation, for example a lodging house, it may be that the owner of that accommodation objects but obviously if it was a private rented accommodation with a front door, we would not envisage extending the right to refuse, to object to a person having an assisted death within the privacy of their own home.

Deputy L.M.C. Doublet:

That right to refuse to participate does apply to owners of care homes.

Director of Health Policy, Government of Jersey:

It does.

[13:00]

Deputy L.M.C. Doublet:

Can you just clarify whether it applies to a lodging house which is a private residence where no care is provided but there might be multiple smaller residences within a house? Does it apply to that situation?

Director of Health Policy, Government of Jersey:

In terms of the law drafting instructions, we need to put some extra thought and clarity into the different forms of places where premises owners could object. If the States decide that people

should be allowed to have an assisted death, of course it is desirable that people are allowed to die in their own home and where they live, and that will be the preliminary principle when bringing forward the legislation, but in respecting that preliminary principle it has to be understood that there are collective living situations where it might not be appropriate. What we need to do is we need to do more work to define what those collective living situations would be. Also, an administrating practitioner must make sure that the place is safe. For example, if it was a shared home and everybody in that shared home violently objected to that person having an assisted death, it might be that the administering practitioner determines it is not safe for that assisted death to go on there.

Deputy L.M.C. Doublet:

Understood. Thank you. Minister, a political question now. Do you think that it is proportionate to allow care homes and nursing homes to refuse their residents access to assisted dying?

The Minister for Health and Social Services:

I have to say, listening to the conversation, it does raise some concerns for me, which I am going to pick up at a later stage. It is clear that somebody should not be denied the opportunity to have an assisted death by virtue of where they live, so I will be having a discussion about where. I do not know if there are provisions for that. Forgive me for not knowing.

Director of Health Policy, Government of Jersey:

There are.

The Minister for Health and Social Services:

Fine. So, if you want to go through those provisions.

Director of Health Policy, Government of Jersey:

Absolutely. If a person was in a care home and the care home objected, then there would be a conversation with that person about an alternative venue. Sorry, “venue” is a terrible word, an alternative location. The most likely place for that would be Jersey General Hospital and there will be active and live conversations about an appropriate place in the hospital for assisted deaths to take place, so not on a general ward.

The Minister for Health and Social Services:

It is something I will take up.

Deputy L.M.C. Doublet:

Could you keep us updated on your considerations in this area?

The Minister for Health and Social Services:

Yes. I am sorry that it has been highlighted at this late stage, but I think we need to make sure that we have got that properly bottomed out.

Deputy L.M.C. Doublet:

Okay. The law is intended to be silent regarding discussions with patients about assisted dying. Can you just clarify where a healthcare professional can choose not to provide any information about assisted dying if the patient has not asked for it?

The Minister for Health and Social Services:

Sorry, if the patient has not asked for it?

Deputy L.M.C. Doublet:

If the patient does not ask for it, is the healthcare professional required to give any information? Ruth, would you like ...

Director of Health Policy, Government of Jersey:

The law is silent on it. The law neither places a duty on a healthcare professional to provide information nor does it prevent a healthcare professional providing information even if the person has not asked.

Deputy L.M.C. Doublet:

If the person asks, what is the duty there?

Director of Health Policy, Government of Jersey:

If the person asks, if the healthcare professional has a conscientious objection to assisted dying - and this is not a matter for law, this is a matter for the professional guidance of the N.M.C. (Nursing and Midwifery Council) and the G.M.C. (General Medical Council) and other professional bodies who produce extensive guidance on conscientious objection - what the healthcare professional needs to do ... it works for termination of pregnancy as well. A healthcare professional has to say: "I have a conscientious objection to assisted dying, termination of pregnancy, whatever it may be, so I cannot provide you advice and support and I suggest that you go and speak to X about it." We will produce leaflets that healthcare professionals can just hand out for the assisted dying service.

Deputy L.M.C. Doublet:

So, they could be handed over. Sure, thank you. On the conscientious objection, I would like to ask about the principle of direct and indirect participation. The panel member who cannot be with us today raised some concerns about the definitions of direct and indirect and how they relate to

other laws that do not have the words “direct” and “indirect”. Could you clarify, Minister or Ruth, what that means in practice?

Director of Health Policy, Government of Jersey:
The other law in Jersey that has a conscientious clause - and of course we are proposing something much broader, which is a right not to participate rather than conscientious objection - the termination of pregnancy law does not talk about direct or indirect. Our Termination of Pregnancy Law is based on the U.K.’s old Termination of Pregnancy Law, which also does not use the words “direct” or “indirect” but there was a Supreme Court case in the U.K. that determined that the U.K.’s Termination of Pregnancy Law, and therefore de facto our Termination of Pregnancy Law, only applied to direct participation because the application to indirect participation essentially was a veto to enabling women to be able to access termination of pregnancy. So, we are modelling that Supreme Court ruling and it is absolutely right that the words “direct” and “indirect” are not in the Termination of Pregnancy Law but the principle of direct and indirect is established through this ruling.

Deputy L.M.C. Doublet:
What would that look like in terms of the proposals that we are discussing now? What would direct participation look like and what would indirect participation look like?

Director of Health Policy, Government of Jersey:
Direct participation would look like a person cannot be forced to directly participate by being a member of the assisted dying service, by not being a member of the assisted dying service but providing a supporting professional opinion or assessment, so a healthcare professional. So that would be examples of direct participation. If the assisted death was taking place in hospital, a nurse from another ward could not be pulled over to assist. That would be direct participation. A pharmacist cannot be forced to directly compound the substance that is going to be used. Indirect would be, for example, an administrator booking an appointment for that doctor to meet that person. That would be indirect participation.

Deputy L.M.C. Doublet:
Thank you. Given the concerns about those terms being hard to define, will there be anything, either within the law or within the guidance, that will define those terms and what they mean?

Director of Health Policy, Government of Jersey:
The interpretation to the guidance will define what the difference between direct and indirect is and also there will be guidance that explains it in more detail.

Deputy C.D. Curtis:

Can I just ask, for example a care assistant working in nursing home who may not want to take part in this but would be normally going into that room and washing the person and knows them, would that be direct or indirect?

Director of Health Policy, Government of Jersey:

The care assistant or any professional who is providing normal care to that person will continue to provide normal care to that person. They cannot say: "I am no longer going to go to your home and provide you with personal support because I know that you have requested an assisted death." They cannot withdraw their services on the basis that they object to that person requesting assisted death but what they absolutely can do is object to in any way directly participating in that assisted death. It does not provide for people to withdraw their support. In the same way in the G.M.C. and N.M.C. guidance, if a woman was to request a termination the doctor cannot say: "You want a termination, therefore I am not going to look at your feet" or whatever it may be. They cannot do that.

Deputy L.M.C. Doublet:

Thank you. We have just some general questions for you, Minister, to end the hearing. We have talked about the weightiness both in volume of documents associated and in terms of the ethical considerations of this important policy area. What has been the most difficult decision that you have had to make or the most difficult area that you have come across?

The Minister for Health and Social Services:

In the past 8 weeks since I have taken up the Ministerial role or overall? Presumably you mean just in ...

Deputy L.M.C. Doublet:

Either.

The Minister for Health and Social Services:

No, I cannot. There is nothing specific that I would say that stands out as being a real dilemma.

Deputy L.M.C. Doublet:

Okay, thank you. In summary, why are you bringing these proposals to the Assembly?

The Minister for Health and Social Services:

First and foremost because it is my duty. It is the will of our Assembly that this takes place and I have, from a distance, followed the whole process and been very impressed by it. That is why: I am expected to, and I am happy to.

Deputy L.M.C. Doublet:

Why do you think it is important that the States Assembly gives this consideration?

The Minister for Health and Social Services:

Because that is the democratic process, that is the expectation.

Deputy L.M.C. Doublet:

Thank you for your time today, Minister.

The Minister for Health and Social Services:

If I can just take the opportunity to thank Ruth because, as you can see, she has got an immense amount of detail and she has been extremely helpful to all of us.

Deputy L.M.C. Doublet:

Yes, that has been evident today.

The Minister for Health and Social Services:

Forgive me for not being able to answer an awful lot of questions but I think you probably understand under the circumstances it would have been very difficult. Thank you for your time.

Deputy L.M.C. Doublet:

Is there anything else you would like to add before we close the hearing?

The Minister for Health and Social Services:

No, not at all. That is fine, thanks.

Deputy C.D. Curtis:

We have got some written questions, have we not?

Deputy L.M.C. Doublet:

Yes, we do have some written questions that we could not fit in today, so we will send those over to you.

The Minister for Health and Social Services:

I am sure Ruth will be very happy to answer them. That is great.

Deputy L.M.C. Doublet:

Thank you very much for your time and your expertise.

The Minister for Health and Social Services:

Thank you. Cheers.

[13:11]