Jersey review

Following extensive debates on the principle and practice of providing an assisted death using lethal drugs or other means, some key points have emerged for consideration. These are listed here and links to relevant reports from the House of Lords recent scrutiny of proposed legislation are attached.

- The safety of any system must be paramount – safety must take precedence over ease of access to lethal drugs.
- All assessment procedures for considering eligibility must carefully explore the reason a person is seeking an assisted death, paying particular attention to:
    - Coercive behaviours by others, undue influence, pressure, or persuasion
    - Abuse within families, of which financial abuse, coercive control and emotional neglect are the commonest.
    - Motivations for an early death related to inheritance.
    - The risk of medical error/malpractice being concealed by an early death, particularly when the clinician is in a position of responsibility towards the patient.
    - The impossibility of accurate prognostication.
- The lethal drugs used in other countries have not been evaluated for human assisted suicide or euthanasia. Their mode of action is unknown and the complication rate, including prolonged time to death, reawakening, fitting, vomiting etc, is significantly high.
- Where lethal drug cocktails are injected by a doctor, the illusion of medical benevolence and the avoidance of the positive action of self-administering lethal drug mixtures, has been shown to result in death rates approximately ten-fold higher than when self-administration is required.
- There should be no ability to waive consent in advance and to waive a final capacity assessment, because this will lead to undetected negligence and will fail to detect criminality from coercive control. A 'best interests' assessment must be completely independent at the time a consent-waiver is considered to be valid, as the patient may have been coerced prior to signing a consent waiver.
- There is extensive unconscious bias in many parts of health care, making this particularly dangerous to leave in the hands of single practitioners without oversight scrutiny of how assessments are undertaken and careful monitoring of all data, including monitoring trends over time.
- Provision of assisted dying cuts across suicide prevention policies. It creates two opposing clinical approaches to suicidality in patients: some suicides that must be prevented and some that are to be facilitated.
- A particular legal issue arises for patients from Jersey being treated in England. If a patient wishes to return to Jersey for an assisted death under Jersey law, the

clinical team caring for them would be committing a crime in arranging transfer back to Jersey as they would be in breach of the Suicide Act in England and Wales, even if legislation is passed in England and Wales. This is because the eligibility criteria for an assisted death in England and Wales would not be fulfilled and therefore assistance would be illegal. This emerged during the Select Committee enquiry on the Terminally Ill Adults (End of Life) Bill over the past month (see oral session with Minister of State for Courts and Legal Services and also the oral session with Sir Max Hill).

- The impact on other patients must be considered in any inpatient setting, as patients are usually very aware of what is happening to other patients.
- Mental capacity and decision making are greatly affected by illness, fear, depression, medication (especially steroids which often increase emotional lability and can cause hypomania or depression; morphine can cause drowsiness and depression; many antiemetics can alter perception).
- The impact on children as relatives has been poorly considered to date (see evidence from the Children's Commissioner). There are increasing reports of complicated grief in children and young people bereaved through an assisted death, as they can feel their love of the parent was insufficient to keep the parent wanting to live and feeling they had a purpose in life.
- Moral injury to staff involved has been poorly evaluated and poorly accounted for.

I hope this is helpful in your deliberations.

Professor the Baroness Finlay of Llandaff FRCP, FRCGP, FRCPEdin, FLSW, FHEA

Report from the House of Lords Select Committee
https://publications.parliament.uk/pa/ld5901/ldselect/hltiabill/204/204.pdf

Report of the Delegated Powers and Regulatory Reform Committee

https://publications.parliament.uk/pa/ld5901/ldselect/lddelreg/171/171.pdf

Report of the Constitution Committee

https://publications.parliament.uk/pa/ld5901/ldselect/ldconst/177/177.pdf