Response to House of Commons Public Bill Committee call for evidence on the Terminally Ill Adults (End of Life) Bill 2024-25

Submitted by Dr Isra Black, UCL Faculty of Laws on 20 January 2025

I am an Associate Professor at the Faculty of Laws, UCL. I am responding to the House of Commons Public Bill Committee's call for expert evidence on the Terminally Ill Adults (End of Life) Bill 2024-25 (henceforth the TIA Bill or the Bill).

I shall offer what I hope is constructive feedback on the provisions of the TIA Bill (as introduced). My evidence submission considers elements of the eligibility criteria for life-ending assistance, as well as the procedural regime envisaged for a person to access to assistance to end their own life. The result of my analysis is 14 recommendations for changes to the Bill. At the end of my evidence, I outline in brief the expertise on which my evidence draws.

Because of the number of recommendations offered and the level of analysis required, it has been necessary to exceed the indicative 2,000 words evidence length. A digest of recommendations follows to assist the Committee.

RECOMMENDATIONS

My evidence submission makes 14 recommendations.

Decision-making capacity: decision-specificity

- **Recommendation 1: The TIA Bill should be amended throughout such that a person's capacity is established by reference to the 'decision to end their own life *with assistance in the manner set out in this Act*'.**

Decision-making capacity: relevant information

- **Recommendation 2: Clause 3 of the TIA Bill should be amended as follows:**

(1) In this Act, references to a person having capacity are to be read in accordance with the Mental Capacity Act 2005.
(2) Supplementary to the provisions of section 3(4) of the Mental Capacity 2005, the information relevant to a person's decision to end their own life with assistance in the manner set out in this Act includes—
  (a) the person's diagnosis and prognosis;
  (b) any treatment available and the likely effect of it;
  (c) any available palliative, hospice or other care, including symptom management and psychological support;
  (d) the nature of the substance that might be provided to assist the person to end their own life (including how it will bring about death);
  (e) any complications that may arise in connection with the self-administration of an approved substance under section 18

Clear, settled and informed wish to die (with assistance)

- Recommendation 3: **References in the TIA Bill to a person's 'clear, settled and informed wish to end their own life' should be amended to a 'clear, settled and informed wish to end their own life *with assistance in the manner set out in this Act*'.**

Information disclosure

- Recommendation 4: **The TIA Bill should include an additional clause in its *Procedure, safeguards and protections* section as follows:**

  A person's wish to end their own life with assistance in the manner set out in this Act shall be regarded as informed if they have received information on—
  (1) their diagnosis and prognosis;
  (2) any treatment available and the likely effect of it;
  (3) any available palliative, hospice or other care, including symptom management and psychological support;
  (4) the nature of the substance that might be provided to assist the person to end their own life (including how it will bring about death);
  (5) any complications that may arise in connection with the self-administration of an approved substance under section 18.

Clear and settled wish

- Recommendation 5: **References in the TIA Bill to a clear and settled wish to die in clauses 7, 8, 12, 13, 18 and in Schedules 2-5 to the Bill should be removed.**
- Recommendation 6: **The TIA Bill should include an additional clause in its *Procedure, safeguards and protections* section as follows:**

  A person's wish to end their own life with assistance in the manner set out in this Act shall be regarded as clear and settled if all stages of the procedure set out in [sections 5-17, Bill as introduced] of the Act have been completed.
- Recommendation 7: **Clause 18(4) of the TIA Bill should be amended as follows:**

  (4) The coordinating doctor must be satisfied, at the time the approved substance is provided, that the person to whom it is provided—
    (a) has capacity to make the decision to end their own life with assistance in the manner set out in this Act,
    (b) ~~has a clear, settled and informed wish to end their own life,~~ wishes to proceed with provision of the approved substance, and
    (c) is requesting provision of that assistance voluntarily and has not been coerced or pressured by any other person into doing so.

Age

- Recommendation 8: **Clause 1(1)(b) of the TIA Bill excluding minors with decision-making capacity from access to life-ending assistance should be removed.**
- Recommendation 9: **The TIA Bill should include an additional clause in its *Procedure, safeguards and protections* section making provision for minors' requests for life-ending assistance to be subject to a welfare determination by the High Court under the Children Act 1989.**

Terminal illness

- **Recommendation 10: Parliament should consider allowing a person to access assistance to end their own life on grounds of unbearable, persistent, and unrelievable suffering caused by illness, disease, or a medical condition.**
- **Recommendation 11: Parliament should gather high-quality evidence enabling it to establish compliance with the legal criteria in jurisdictions that permit life-ending assistance on terminal illness and on suffering grounds, respectively.**

Procedural regime

- **Recommendation 12: A High Court declaration as to whether the TIA Bill's eligibility criteria for life-ending assistance are met should not be required as a matter of routine.**
- **Recommendation 13: Clause 12 of the TIA Bill mandating court involvement should be removed, with consequential amendments throughout the Bill.**
- **Recommendation 14: The TIA Bill should include an additional clause in its *Procedure, safeguards and protections* section permitting a person seeking life-ending assistance or a coordinating or independent doctor to apply to the High Court for a declaration on matters of capacity, voluntariness, and ordinary residence.**

A. THE TIA BILL'S ELIGIBILITY CRITERIA

Decision-making capacity: decision-specificity

A1. The TIA Bill sets as one of the conditions for access to assistance to die that a person 'has the capacity to make a decision to end their own life'.[1] A person's decision-making capacity is to be established by reference to the provisions of the Mental Capacity Act 2005 (MCA 2005).[2]

A2. Under the MCA 2005, the presumption of decision-making capacity provided for by section 1(2) of the Act is rebutted if—in accordance with section 2(1):

> in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.

A3. Under the MCA 2005, section 2(1), therefore, a lack of capacity requires an inability to make a decision at a time caused by a deficit in the mind or brain. Decision-making incapacity is *functional* (the ability), *causal* (the deficit), as well as both *decision-specific* (the 'matter') and *time-specific* (the 'material time').

A4. **The 'matter' specified in the TIA Bill for the purposes of decision-making capacity is a person's ending their own life. This is overbroad.** There are manifold ways in which a person may end their own life; a person's decision-making capacity may vary across different means of bringing about death. A person may have capacity in respect of a

[1] TIA Bill, clause 1(1).
[2] TIB Bill, clause 3.

decision to die using medical means (eg using a high dose of sedatives), but lack capacity to decide to end their own life via means that involve a high risk of failure, or which are likely to be violent, painful, or causative of suffering.

A5. **Since the TIA Bill makes provision for assistance to die only via access to (approved) lethal substances,[3] it is irrelevant whether a person requesting assistance has capacity to end their own life by other means.**

A6. **Recommendation 1: The TIA Bill should be amended throughout such that a person's capacity is established by reference to the 'decision to end their own life *with assistance in the manner set out in this Act*'.**

Decision-making capacity: relevant information

A7. For the purposes of the MCA 2005, section 2(1) capacity test, a person will be unable to make a decision if—in accordance with section 3(1) of the Act—they are unable to do any of the following things:

> (a) to understand the information relevant to the decision,
> (b) to retain that information,
> (c) to use or weigh that information as part of the process of making the decision, or
> (d) to communicate [their] decision…

A8. Important to note is that ability to make a decision under the MCA 2005, section 3(1) is assessed against the 'information relevant to the decision', that is, the 'matter' about which a person's capacity is in question. It follows that the capacity-relevant information varies according to the specific decision a person faces at a particular time.

A9. The MCA 2005, section 3(4) provides that:

> The information relevant to a decision includes information about the reasonably foreseeable consequences of—
> (a) deciding one way or another, or
> (b) failing to make the decision.

A10. The lack of specificity with regard to the substance or content of capacity-relevant information in section 3(4) of the Act is understandable, given its breadth of application.

A11. The TIA Bill, clause 3 states:

> In this Act, references to a person having capacity are to be read in accordance with the Mental Capacity Act 2005.

A12. **There is a missed opportunity to specify the information relevant to a person's capacity to end their own life (with assistance in the manner foreseen) in the TIA Bill; doing this would promote consistency and confidence in the assessment of capacity.**

A13. Plausibly, **the information relevant to a person's capacity to end their own life with assistance under the Bill includes the information that medical practitioners must explain to and discuss with the person seeking assistance during the mandated**

[3] TIA Bill, clauses 18-20.

doctors' assessments.[4] Provision of information is important not only as an independent criterion for the validity of a person's decision to die with assistance (see paras A18-A21), but also as the basis for the evaluation of their capacity.

A14. **Recommendation 2: Clause 3 of the TIA Bill should be amended as follows:**

(1) In this Act, references to a person having capacity are to be read in accordance with the Mental Capacity Act 2005.
(2) Supplementary to the provisions of section 3(4) of the Mental Capacity 2005, the information relevant to a person's decision to end their own life with assistance in the manner set out in this Act includes—
  (a) the person's diagnosis and prognosis;
  (b) any treatment available and the likely effect of it;
  (c) any available palliative, hospice or other care, including symptom management and psychological support;
  (d) the nature of the substance that might be provided to assist the person to end their own life (including how it will bring about death);
  (e) any complications that may arise in connection with the self-administration of an approved substance under section 18

Clear, settled and informed wish to die

A15. The TIA Bill sets as one of the conditions for access to assistance to die that a person has an 'clear, settled and informed wish to end their own life'.[5]

A16. Consistent with the discussion above in respect of decision-making capacity, **this provision should be fine-tuned to the life-ending assistance envisaged under the TIA Bill.**

A17. **Recommendation 3: References in the TIA Bill to a person's 'clear, settled and informed wish to end their own life' should be amended to a 'clear, settled and informed wish to end their own life *with assistance in the manner set out in this Act*'.**

Information disclosure

A18. Under general health law in England and Wales, a decision to consent to medical treatment will be *valid* if 'the patient is informed in broad terms of the nature of the procedure which is intended'.[6] This test—whose satisfaction provides a doctor a defence to an action in tort (or prosecution under criminal law) for trespass to the person—is relatively undemanding.

A19. **In order to avoid confusion between general health law and the legal regime under the TIA Bill, it is desirable to clarify the standard of disclosure of information to an individual if their wish to ending their own life with assistance is to count as informed for the purposes of the Bill.**

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[4] TIA Bill, clause 9(2)(b)-(c)
[5] TIA Bill, clause 1(2)(a).
[6] *Chatterton v Gerson* [1981] QB 432, 443 (Bristow J).

A20. **Recommendation 4: The TIA Bill should include an additional clause in its *Procedure, safeguards and protections* section as follows as follows:**

A person's wish to end their own life with assistance in the manner set out in this Act shall be regarded as informed if they have received information on—

(1) their diagnosis and prognosis;
(2) any treatment available and the likely effect of it;
(3) any available palliative, hospice or other care, including symptom management and psychological support;
(4) the nature of the substance that might be provided to assist the person to end their own life (including how it will bring about death);
(5) any complications that may arise in connection with the self-administration of an approved substance under section 18.

A21. It is not necessary to go further in this new clause and require that an individual understand and appreciate the information disclosed to them, since a person's grasp and use of the information relevant to the wish to end their own life with assistance is assessed by the decision-making capacity condition of the eligibility criteria..

Clear and settled wish

A22. The criteria of a clear and settled wish to die (with assistance) speak to **different desiderata.** First, that the wish to die is **unambiguous**, second, that the wish to die is **enduring or stable over time**.

A23. **The provisions of the TIA Bill as introduced create uncertainty as to the standard for establishing whether a person's wish to die is clear and settled.** This is because **during each of the doctors' assessments, as well as at the court declaration stage, there is a requirement to ascertain that the person seeking life-ending assistance has a clear and settled wish to die.**

A24. So drafted, **the TIA Bill requires a judgement on the part of doctors and the courts in respect of the clarity and stability of the wish to die. The basis on which these judgements are to be made is unarticulated in the Bill. This discretionary space is undesirable.**

A25. **A preferable alternative is for the TIA Bill to specify that the conditions of a clear and settled wish to die will be met just when an individual has completed all stages of the process set out in the Bill, namely** (as introduced) **both declarations, all doctors' assessments, court declaration, all reflection periods.**

A26. **The shift from a substantive to a formal (or procedural) criterion of a clear and settled wish to die will promote legal certainty.**

A27. **Recommendation 5: References in the TIA Bill to a clear and settled wish to die in clauses 7, 8, 12, 13, 18 and in Schedules 2-5 to the Bill should be removed.**

A28. **Recommendation 6: The TIA Bill should include an additional clause in its *Procedure, safeguards and protections* section as follows:**

> A person's wish to end their own life with assistance in the manner set out in this Act shall be regarded as clear and settled if all stages of the procedure set out in [clauses 5-17, Bill as introduced] of the Act have been completed.

A29. **Recommendation 7: Clause 18(4) of the TIA Bill should be amended as follows:**

> (4) The coordinating doctor must be satisfied, at the time the approved substance is provided, that the person to whom it is provided—
> (a) has capacity to make the decision to end their own life with assistance in the manner set out in this Act,
> (b) ~~has a clear, settled and informed wish to end their own life,~~ wishes to proceed with provision of the approved substance, and
> (c) is requesting provision of that assistance voluntarily and has not been coerced or pressured by any other person into doing so.

Age

A30. Under the TIA Bill as introduced, only individuals who have attained the age of majority—18 years of age—may access assistance to end their own life.[7]

A31. **The exclusion of minors with decision-making capacity from access to life-ending assistance lacks a clear, principled basis.**

A32. **Under general health law in England and Wales, minors may be able to give legally *valid* consent to or refusal of medical treatment.** The consents of minors aged 16 and 17 years, have the same legal status as those given by adults; minors' decisions to consent to medical treatment are—other things equal—legally *valid* unless the presumption of decision-making capacity in the MCA 2005 is rebutted following application of the test in section 2(1) of the Act (see paras A2-A3, A7-A9).

A33. For minors aged 15 years or younger, their consents to medical treatment are—other things equal—legally *valid* if the minor in this age category rebuts the presumption of decision-making incapacity by satisfying the conditions of the *Gillick* test. In outline, a minor has capacity when they '[achieve] a sufficient understanding and intelligence to enable him or her to understand fully what is proposed'.[8]

A34. **Under the law in England and Wales, minors' legally *valid* medical decisions are not always legally *effective*.**[9] Under the 'concurrent consents' doctrine, a minor's competent refusal (that is, a refusal made with decision-making capacity) of medical treatment may be overridden by the consent of parents or a court—thereby providing a legal basis for treatment to proceed.[10]

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[7] TIA Bill, clause 1(1)(b).
[8] *Gillick v West Norfolk and Wisbech AHA* [1986] AC 112, 188-189 (Lord Scarman).
[9] See Isra Black, 'Asymmetry of Adolescent Decision-Making Capacity and Rational Choice' in Lisa Forsberg et al (eds), Consenting Children: Autonomy, Responsibility, Wellbeing (forthcoming, Proceedings of the British Academy 2025).
[10] *Re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64 (CA); *Re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11 (CA).

A35. In the leading case of *Re W*, Lord Donaldson MR indicates that the courts possess the power to override the competent consent of a minor to medical treatment—thereby rendering medical treatment unlawful to administer.[11] This would make (also) for a 'concurrent refusals' doctrine in England and Wales.[12]

A36. It is likely that **some minors—particularly those with experience of severe illness**[13]**—have the capacity to request life-ending assistance of the kind envisaged in the TIA Bill.**

A37. And **the concerns that typically justify overriding minors' competent medical decisions—concerns grounded in the wellbeing of adolescents** that may make it necessary to 'shield' a competent minor from the full consequences of (and full responsibility for) their choices[14]—**may be less salient in the context of life-ending assistance than in other medical contexts** (such as refusals of life-prolonging treatment).

A38. A minor who, for example, has a terminal illness under the TIA Bill,[15] has—by definition—a life-limiting condition. The wellbeing-based judgement as to whether to respect a request for life-ending assistance may therefore take place in a context in which death is not a distant prospect, but rather on the horizon. It is plausible that **in some cases, it is worse in terms of a competent minor's wellbeing for other parties to deny them control over the manner and moment of death than it is to respect their request for assistance to end their own life.**

A39. **Recommendation 8: Clause 1(1)(b) of the TIA Bill excluding minors with decision-making capacity from access to life-ending assistance should be removed.**

A40. **Recommendation 9: The TIA Bill should include an additional clause in its *Procedure, safeguards and protections* section making provision for minors' requests for life-ending assistance to be subject to a welfare determination by the High Court under the Children Act 1989.**

Terminal illness

A41. The Commons, by giving the TIA Bill its second reading, has endorsed the principle of permitting people who are terminally ill access to life-ending assistance.

A42. I would respectfully **invite reconsideration of the choice for access based on terminal illness *only*.** There are **principled grounds for permitting access to life-ending assistance on the alternative grounds of unbearable, persistent, and unrelievable suffering** (henceforth **'suffering grounds'**) **caused by illness, disease, or a medical**

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[11] *Re W*[1993] Fam 64 (CA), 83-84.
[12] See Anthony Skelton, Lisa Forsberg, and Isra Black, 'Overriding Adolescent Refusals of Treatment' (2021) 20(3) Journal of Ethics and Social Philosophy 221-247.
[13] See Isra Black, Lisa Forsberg, and Anthony Skelton, 'Transformative choice and decision-making capacity' (2023) 139(October) Law Quarterly Review 654.
[14] Anthony Skelton, Lisa Forsberg, and Isra Black, 'Overriding Adolescent Refusals of Treatment' (2021) 20(3) Journal of Ethics and Social Philosophy 221-247; 'Treating Adolescents Differently' in Lisa Forsberg et al (eds), Consenting Children: Autonomy, Responsibility, Wellbeing (forthcoming, Proceedings of the British Academy 2025).
[15] TIA Bill, clause 2(1).

condition. And **it is yet to be established that permitting access to life-ending assistance on suffering grounds is unsafe**.

A43. **Terminal illness is not a sufficient** (or an in and of itself) **reason for permitting the provision of life-ending assistance.** Rather, we have principled reasons to provide people who are terminally ill access to end their own life because the experience of a life-limiting condition—for example, its symptoms, its implications for (lost) autonomy and wellbeing, its effect on loved ones—makes out the suffering grounds.

A44. **Other, non-terminal illnesses, diseases, or medical conditions may cause a person to experience their own life in a way that meets the suffering grounds.** For example, Tony Nicklinson described life with 'locked in' syndrome as 'dull, miserable, demeaning, undignified and intolerable'.[16] Nicklinson (who ended his own life by combination of self-starvation and refusal of medical treatment) would not be eligible for life-ending assistance under the TIA Bill.[17]

A45. **Some people with non-terminal conditions have as strong a claim to assistance to end their own lives as people with terminal illness.** As Lord Neuberger observed in the Supreme Court judgment in Nicklinson's case:

> There seems to me to be significantly more justification in assisting people to die if they have the prospect of living for many years a life that they regarded as valueless, miserable and often painful, than if they have only a few months left to live.[18]

A46. It is plausible that **the TIA Bill's drafters have narrowed a person's eligibility for life-ending assistance to terminal illness on what we might describe as safety or protective grounds.**[19] A restriction of eligibility to people who are terminally ill, it might be thought, makes it less likely that people who neither wish to die (with assistance or otherwise), nor who meet the eligibility criteria will gain access to life-ending means.

A47. Yet **there is no conclusive evidence that legal regimes that permit access to life-ending assistance on suffering grounds are unsafe in their operation.**[20] Perhaps tellingly, **no jurisdiction internationally that permits assistance to die on suffering grounds has repealed its legislation or narrowed its scope**. It would be remarkable for participants in the operation and review of suffering-based regimes—and the public in these diverse jurisdictions—to have acquiesced to or endorsed the practice of life-ending assistance when the legal criteria are not met.

A48. **Recommendation 10: Parliament should consider allowing a person to access assistance to end their own life on grounds of unbearable, persistent, and unrelievable suffering caused by illness, disease, or a medical condition.**

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[16] *R (Nicklinson) v Ministry of Justice* [2014] UKSC 38 [3] (Lord Neuberger).
[17] *Nicklinson* [2014] UKSC 38 [6] (Lord Neuberger).
[18] *Nicklinson* [2014] UKSC 38 [122]
[19] See HC Deb, 'Terminally Ill Adults (End of Life) Bill' 2024/11/29, vol 757 cols 99-1088 https://hansard.parliament.uk/commons/2024-11-29/debates/796D6D96-3FCB-4B39-BD89-67B2B61086E6/TerminallyIllAdults(EndOfLife)Bill accessed 25/01/19.
[20] See House of Commons, Health and Social Care Committee Report on Assisted Dying/Assisted Suicide (HC 321, 2024).

A49. **Recommendation 11: Parliament should gather high-quality evidence enabling it to establish compliance with the legal criteria in jurisdictions that permit life-ending assistance on terminal illness and on suffering grounds, respectively.**

B. THE TIA BILL'S PROCEDURAL REGIME

B1. **The TIA Bill sets out a detailed procedural regime whose purpose is to ensure that access to life-ending assistance operates within the legal criteria.** In outline, the process is as follows:[21]

- First declaration requesting provision of life-ending assistance (witnessed by the coordinating doctor, as well as non-disqualified person)
- First assessment and statement by the coordinating doctor
- Seven (7) day reflection period
- Assessment and statement by the independent doctor
- High Court declaration that legal criteria for life-ending assistance are met (option to appeal in the event of refusal)
- Fourteen (14) day reflection period (48 hours if death expected within one month)
- Second declaration requesting provision of life-ending assistance (witnessed by the coordinating doctor, as well as non-disqualified person)
- Second statement by the coordinating doctor
- Provision of assistance
- Final statement from coordinating doctor

B2. **The TIA Bill's requirement for a High Court (or Court of Appeal) declaration that the legal criteria are met constitutes an excessive burden on people seeking life-ending assistance**.

B3. **People who navigate legal processes experience them too.** There is a risk that **some people who meet the TIA Bill's eligibility criteria may not request life-ending assistance because of the additional experiential burden involved in the court declaration stage of the process**. We might describe this the phenomenon—where people do not avail themselves of their legal entitlements because of the process involved—as **'process hesitancy'**.

B4. Alternatively, **some people who meet the TIA Bill's eligibility criteria may continue to seek life-ending assistance abroad in jurisdictions that do not restrict access to residents**, for example, Switzerland,[22] **because of process hesitancy**.

B5. **It is unclear whether the court declaration stage of the process strikes the appropriate balance between protection**—ensuring only people who meet the TIA Bill's eligibility criteria receive life-ending assistance—**and access**—ensuring people who meet the Bill's eligibility criteria can receive life-ending assistance.

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[21] TIA Bill, clauses 5-9, 12-13, 18, 21. For a helpful visual representation of the process, see House of Commons Library, Research Briefing: The Terminally Ill Adults (End of Life) Bill 2024-25 (2024) https://researchbriefings.files.parliament.uk/documents/CBP-10123/CBP-10123.pdf accessed 2025/01/19, para 3.1.

[22] See House of Commons, Health and Social Care Committee Report on Assisted Dying/Assisted Suicide (HC 321, 2024), paras 16-40.

B6. **The inclusion of a court declaration stage is out of step with the practices of other jurisdictions that permit life-ending assistance.**[23] In and of itself, this is not a reason to forego such a stage; however, **practices in other jurisdictions offer an indication of the appropriate balance between protection and access**, even if they cannot provide evidence as to whether court involvement of the kind envisaged by the TIA Bill yields more protection.

B7. **Routine court involvement in the procedural regime for life-ending assistance may have a chilling effect on doctors' willingness to be involved in its provision.** The TIA Bill's court declaration stage **risks signalling to doctors that their judgements are not to be trusted**. And doctors may be unwilling to assist people to end their own lives because of **the risk of reputational damage that may follow the High Court taking a negative view on doctors' good faith judgements** as to whether the eligibility criteria have been met in individual cases. **These risks may create negative, provider-side impacts on access to life-ending assistance under the TIA Bill.**

B8. Alternatively, it might be advanced that routine court involvement would instil confidence among doctors that the eligibility criteria are met in individual cases.

B9. As an **intermediate position** on court involvement, **the TIA Bill might provide for application to the High Court in cases of uncertainty or disagreement as to whether the eligibility criteria are met on matters in which the courts possess expertise, namely, capacity and voluntariness, and ordinary residence**. An analogous provision is the MCA 2005, section 15 power to make declarations.

B10. If Parliament accepts **Recommendations 8 and 9** above, the **courts would be routinely involved in making a welfare determination under the Children Act 1989 in the case of a competent minor requesting life-ending assistance**.

B11. **Recommendation 12: A High Court declaration as to whether the TIA Bill's eligibility criteria for life-ending assistance are met should not be required as a matter of routine.**

B12. **Recommendation 13: Clause 12 of the TIA Bill mandating court involvement should be removed, with consequential amendments throughout the Bill.**

B13. **Recommendation 13: The TIA Bill should include an additional clause in its *Procedure, safeguards and protections* section permitting a person seeking life-ending assistance or a coordinating or independent doctor to apply to the High Court for a declaration on matters of capacity, voluntariness, and ordinary residence.**

*** * * EVIDENCE CONTINUES ON NEXT PAGE * * ***

[23] See Penney Lewis, 'Should Assisted Dying Require the Consent of a High Court Judge?' in Ben P. White and Lindy Willmott (eds), International Perspectives on End-of-Life Law Reform: Politics, Persuasion and Persistence (Cambridge University Press 2021).

C. EXPERTISE

C1. I research and teach at the intersection of law and philosophy (ethics) on matters of health and medicine. My published academic work engages extensively with the subject of assisted death,[24] as well as that of the law of medical treatment (including mental capacity law and refusals of treatment, both especially concerning adolescents).[25]

C2. I have made substantial contributions to public and policy discussion of assisted death. In 2024, I was an expert informant to the Nuffield Council on Bioethics Citizens' Jury on assisted dying, presenting on eligibility criteria and safeguards for assisted death. In 2021, I was an expert informant to the Jersey Assisted Dying Citizens' Jury, presenting on eligibility criteria for assisted death. In 2023, I responded to the Government of Jersey's Public Consultation on Assisted Dying; my recommendations for clarifications to the eligibility criteria in the law reform proposal were acknowledged in the Government's Consultation Feedback Report (2023) and feature in the Proposition considered by the States of Jersey (2024). In 2012, Professor and Penney Lewis and I cowrote a briefing paper for the Commission on Assisted Dying on 'The Effectiveness of Legal Safeguards in Jurisdictions that Allow Assisted Dying'; the briefing paper has had significant international policy impact.

C3. I would be pleased discuss my evidence submission further with the Committee and MPs and can be reached at isra.black@ucl.ac.uk.

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[24] See Isra Black, 'Dual or single gauge? Govert den Hartogh's 'dual-track' assisted death' (2024) 45(1) Filosofie & Praktijk 27-44; Isra Black, 'A Pro Tanto Moral Case for Assisted Death' in Sue Westwood (ed), *Regulating the end of life: death rights* (Routledge 2021); Isra Black, 'Novel Beings and Assisted Nonexistence' (2021) 30(3) Cambridge Quarterly of Healthcare Ethics 543-555; Isra Black, 'Patients, physicians and law at the end of life in England and Wales' in Ruth E Board et al (eds), *End of Life Choices for Cancer Patients* (EBN Health 2020); Isra Black, 'Better off dead? Best interests assisted death' (PhD thesis, King's College London 2016); Isra Black, 'Existential suffering and the extent of the right to physician-assisted suicide in Switzerland: *Gross v Switzerland*' (2014) 22(1) Med Law Rev 109; Isra Black, 'A postscript to *Gross v Switzerland*' (2014) 22(4) Med Law Rev 656; Penney Lewis and Isra Black, 'Adherence to the request criterion in jurisdictions where assisted dying is lawful? A review of the criteria and evidence in the Netherlands, Belgium, Oregon, and Switzerland' (2013) 41(4) Journal of Law, Medicine and Ethics 885; Penney Lewis and Isra Black, 'Reporting and scrutiny of reported cases in four jurisdictions where assisted dying is lawful: A review of the evidence in the Netherlands, Belgium, Oregon and Switzerland' (2013) 4 Medical Law International 221; Penney J Lewis and Isra Black, *'The effectiveness of legal safeguards in jurisdictions that allow assisted dying', Briefing Paper for the Commission on Assisted Dying* (Demos, 2012); Isra Black, 'Suicide assistance for mentally disordered individuals in Switzerland and the state's positive obligation to facilitate dignified suicide: *Haas c. Suisse*' (2012) 20(1) Med Law Rev 157.

[25] See Isra Black, 'Asymmetry of Adolescent Decision-Making Capacity and Rational Choice' in Lisa Forsberg, Isra Black and Anthony Skelton (eds), *Consenting Children: Autonomy, Responsibility, Wellbeing* (forthcoming, Proceedings of the British Academy 2025); Anthony Skelton, Isra Black and Lisa Forsberg, 'Treating Adolescents Differently' in Lisa Forsberg, Isra Black and Anthony Skelton (eds), *Consenting Children: Autonomy, Responsibility, Wellbeing* (forthcoming, Proceedings of the British Academy 2025); Isra Black, Lisa Forsberg and Anthony Skelton, 'Transformative choice and decision-making capacity' (2023) 139(October) Law Quarterly Review 654; Anthony Skelton, Lisa Forsberg and Isra Black, 'Overriding Adolescent Refusals of Treatment' (2021) 20(3) Journal of Ethics and Social Philosophy 221-247; Isra Black, 'Refusing Life-Prolonging Medical Treatment and the ECHR' (2018) 38(2) Oxford Journal of Legal Studies 299-327