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Public Bill Committee

TERMINALLY ILL ADULTS (END OF LIFE) BILL

Eighteenth Sitting

Wednesday 5 March 2025

(Morning)

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Sunday 9 March 2025

The Committee consisted of the following Members:

Chairs: † Peter Dowd, Clive Efford, Sir Roger Gale, Carolyn Harris, Esther McVey

† Abbott, Jack *(Ipswich)* (Lab/Co-op)
† Atkinson, Lewis *(Sunderland Central)* (Lab)
† Campbell, Juliet *(Broxtowe)* (Lab)
† Charalambous, Bambos *(Southgate and Wood Green)* (Lab)
† Francis, Daniel *(Bexleyheath and Crayford)* (Lab)
Gordon, Tom *(Harrogate and Knaresborough)* (LD)
† Green, Sarah *(Chesham and Amersham)* (LD)
† Hopkins, Rachel *(Luton South and South Bedfordshire)* (Lab)
† Joseph, Sojan *(Ashford)* (Lab)
† Kinnock, Stephen *(Minister for Care)*
† Kruger, Danny *(East Wiltshire)* (Con)
† Leadbeater, Kim *(Spen Valley)* (Lab)
† Malthouse, Kit *(North West Hampshire)* (Con)
† Olney, Sarah *(Richmond Park)* (LD)
† Opher, Dr Simon *(Stroud)* (Lab)
† Paul, Rebecca *(Reigate)* (Con)
† Richards, Jake *(Rother Valley)* (Lab)
† Sackman, Sarah *(Minister of State, Ministry of Justice)*
† Saville Roberts, Liz *(Dwyfor Meirionnydd)* (PC)
† Shah, Naz *(Bradford West)* (Lab)
† Shastri-Hurst, Dr Neil *(Solihull West and Shirley)* (Con)
† Tidball, Dr Marie *(Penistone and Stocksbridge)* (Lab)
† Woodcock, Sean *(Banbury)* (Lab)

Lynn Gardner, Lucinda Maer, Jonathan Whiffing, *Committee Clerks*

† **attended the Committee**

Public Bill Committee

Wednesday 5 March 2025

(Morning)

[Peter Dowd *in the Chair*]

Terminally Ill Adults (End of Life) Bill

9.25 am

The Chair: Will hon. Members please ensure that all electronic devices are turned off or switched to silent mode? Tea and coffee are not allowed in the Committee Room. We are continuing line-by-line consideration of the Terminally Ill Adults (End of Life) Bill. I remind Members that the most valuable of all talents is never using two words when one will do. I take that from Thomas Jefferson.

Clause 5

Initial request for assistance: first declaration

Naz Shah (Bradford West) (Lab): I beg to move amendment 290, in clause 5, page 3, line 13, at end insert

"who is not a physician associate or doctor in any training grade or in postgraduate training or a locum tenens post and—".

This amendment would exclude physician associates and doctors in training from acting as a coordinating doctor.

The Chair: With this it will be convenient to discuss the following:

Amendment 185, in clause 5, page 3, line 14, leave out from "who" to end of line 15 and insert

"meets the requirements specified in regulations under subsection (3A)".

This amendment and Amendment 186 impose a duty on the Secretary of State to make regulations about the training, qualifications and experience required in order to act as the coordinating doctor.

Amendment 335, in clause 5, page 3, line 14, after "such" insert "specialised".

This amendment is linked with NC12.

Amendment 52, in clause 5, page 3, line 15, leave out from "State" to end and insert

"must specify by regulations, including experience of managing terminal illnesses,".

This amendment would require the coordinating doctor to have experience of managing terminal illness.

Amendment 359, in clause 5, page 3, line 18, at end insert—

"(ba) who has conducted the preliminary discussion in accordance with section 4,".

This amendment requires that the coordinating doctor has conducted a preliminary discussion prior to witnessing the signing of the first declaration.

Amendment 186, in clause 5, page 3, line 23, at end insert—

"(3A) The Secretary of State must by regulations make provision about the training, qualifications and experience that a registered medical practitioner must have in order to act as the coordinating doctor.

(3B) The regulations must include training about—

(a) assessing capacity;

(b) assessing whether a person has been coerced or pressured by any other person.

(3C) Subject to that, the regulations may in particular provide that the required training, qualifications or experience is to be determined by a person specified in the regulations."

See the statement for Amendment 185.

Amendment (a) to amendment 186, after

"(b) assessing whether a person has been coerced or pressured by any other person."

insert

"(c) specific and up-to-date training on reasonable adjustments and safeguards for autistic people and people with a learning disability."

Amendment 340, in clause 5, page 3, line 23, at end insert—

"(3A) The Secretary of State must make regulations under subsection 3(a) specifying specific and up to date training on reasonable adjustments and safeguards for autistic people and people with a learning disability."

Amendment 427, in clause 5, page 3, line 23, at end insert—

"(3A) In Wales, all reasonable steps must be taken to ensure the practitioner under subsection (3) has fluent proficiency in the Welsh language if services or functions in the Act are to be provided to an individual in Welsh."

Amendment 20, in clause 5, page 3, line 25, at end insert—

"(4A) Regulations under subsection (3)(a) must specify that training in respect of domestic abuse, including coercive control and financial abuse is mandatory."

This amendment would require the registered medical practitioner acting as the coordinating doctor to have undertaken training on domestic abuse, including coercive control and financial abuse.

Amendment 336, in clause 8, page 5, line 13, after "such" insert "specialised".

This amendment is linked with NC12.

Amendment 337, in clause 19, page 13, line 20, after "such" insert "specialised".

This amendment is linked with NC12.

New clause 12—*Obligations related to training*—

"(1) No registered medical practitioner or other health professional is under any duty to opt in to undertake specialised training wholly or largely relating to the provision of assisted dying in accordance with this Act.

(2) No medical practitioner or other health professional who has carried out training as may be specified by the Secretary of State under—

(a) section 5(3)(a),

(b) section 8(6)(a), or

(c) section 19(2)(b),

is under any duty to participate in the provision of assisted dying under the terms of this Act."

This new clause would set out that a registered medical practitioner or other health professional is not under any duty to undertake training in relation to the provision of assisted dying. And anyone who undertakes such training is not under a duty to provide assisted dying under the Act.

Naz Shah: Amendment 290 was tabled by my hon. Friend the Member for York Central (Rachael Maskell). Clarity is needed on who a medical practitioner is. With the regulation of physician associates, there was much unease from the British Medical Association and others on the role and function of the new profession. Although I do not want to debate the merit of this today, it is clear that involvement in the assisted dying process requires someone of significant experience to support a patient while undertaking complex assessments and co-ordinating their care between specialists and others.

In some jurisdictions, we have heard that clinicians have extensive clinical experience, whereas they do not in others. Therefore, being able to determine the level of experience and competencies of the medical practitioner is important to ensure that the patient is receiving care from someone who has significant practice expertise. A doctor in training, whether as a specialist or general practitioner, although making very specific clinical decisions, should not be deemed as having the experience, competencies or breath of experience for the purposes of this process. An associate practitioner should also not be deemed to reach these thresholds. Amendment 290 would therefore show the public that the person who would act as the co-ordinating doctor held such experience, and that there was no doubt in their standing to register for such a role. The public can already be confused on the exact status of the clinician they are under or indeed the profession itself. Including this safeguard would ensure that the patient's interests are upheld.

Rachel Hopkins (Luton South and South Bedfordshire) (Lab): It is a pleasure to serve under your chairship, Mr Dowd.

I rise to speak in support of amendment 185, in the name of the hon. Member for Spen Valley, the Bill's promoter, regarding training requirements that need to be made by regulation. It would place a duty on the Secretary of State to make regulations about training qualifications and experience required in order to act as a co-ordinating doctor. Similarly, amendment 186 says that the regulations should specifically include training relating to the assessment of capacity and assessing whether a person is being coerced or pressured by any other person. Proposed new subsection (3C), introduced by amendment 186, would make provision that

"the required training, qualifications or experience is to be determined by a person specified in the regulations."

In making those regulations, reflection of expertise is vital. We heard from many experts who gave us evidence about the importance of training, development and mentorship, which we would expect to see covered in the regulations. Placing those requirements in regulations would mean that they could be developed through consultation with experts and stakeholders, after gaining a wide range of feedback. It would also future-proof the requirement of any training to be developed and strengthened through future experience.

As part of the safeguards in the Bill, the key principles around assessing capacity and potential coercion are really important. I am therefore minded to press the hon. Member for Spen Valley also to support amendment 20, in the name of my hon. Friend the Member for Lowestoft (Jess Asato), which states:

"Regulations under subsection (3)(a) must specify that training in respect of domestic abuse, including coercive control and financial abuse is mandatory."

That would provide further clarity, and would further strengthen training on assessing coercion in all senses of the word as part of the safeguards, which many Members, even in the earlier debates, have said that it is so important that they see. I agree, and I hope that the promoter of the Bill will support amendment 20.

Daniel Francis (Bexleyheath and Crayford) (Lab): I rise to speak to the amendments in my name—namely, new clause 12 and amendments 336, 337 and 335. Yesterday, we spoke about the evidence we received from the British Medical Association. I accept that there is some crossover between my amendments and the amendments of the Bill's promoter, my hon. Friend the Member for Spen Valley, on training.

The British Medical Association stated, with regard to my amendments:

"We strongly urge MPs to support these amendments which would define the 'training' explicitly in the Bill as specialised training to provide assisted dying, undertaken by those who opt in…We have been vocal that the Bill should be based on an opt-in model…during the Committee's oral evidence sessions. Reinforcing this, we believe NC12 and Amendments 335-337 would make two important aspects of this provision in the Bill clearer:

1. That providing assisted dying is not, and would not in the future, be expected of all doctors—the Bill's current all-encompassing reference simply to 'training' does not preclude this training being prescribed as standard general medical training via the regulations, in which case it would apply to all doctors and make the opt-in redundant. Specifying that it is 'specialised' training on the face of the Bill, and making clear that there is no obligation on doctors to undergo the training, would safeguard the opt-in model in the Bill's first principles.

2. That only those who undergo specialised, tailored training on assisted dying could provide the service – during the oral evidence sessions, there has been much discussion about the importance of specialised training for those who opt in to carry out the service. Specialised training for those providing the service is essential for doctors and provides additional protection and safeguards for patients—it should be explicitly referenced in the Bill."

We heard in our oral evidence sessions from others, including Dr Ahmedzai, on the need for training. He said:

"I personally believe that it would be advantageous if there was formal training, as Dr Clarke has mentioned, specifically to have the kinds of conversations that we now talk about, such as about psychological issues and suicidal tendencies."—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee,* 28 January 2025; c. 69, Q82.]

I now turn to two amendments in my name: amendment 340 and amendment (a) to amendment 186. Both amendments relate to training for those with learning disabilities and autism. We had a similar discussion on a previous clause, and I know that further amendments are likely to be tabled on the matter, but as I said yesterday, they are not currently on the amendment paper.

I heard and welcome what my hon. Friend the Member for Luton South and South Bedfordshire has said about amendment 20. Putting that training in the Bill is hugely important, and I believe the same is true in relation to training for those with learning disabilities and autism, as set out in to amendments 340 and amendment (a) to amendment 186, particularly given my concerns and those of others about whether we end up with clause 3 relating to the Mental Capacity Act 2005.

Dr Marie Tidball (Penistone and Stocksbridge) (Lab): I thank my hon. Friend for his amendments, and I agree with their principle. My concern is that, again, people with mental disorders are left out. Does he agree that, if there were a way to amend the Bill later so that they could be incorporated in these proposals, that would be a positive step forward?

Daniel Francis: I would welcome that as a positive step forward—I think there is probably still some work to do in that regard. My hon. Friend and I will have conversations on the wording of that future amendment, but at the moment we are discussing the amendments that stand before us. Any future amendments that may be tabled are not for us currently to consider.

Dr Tidball: As my hon. Friend knows, I have a great deal of respect for him, so I gently say that if he brings forward similar amendments later in the Bill, I would be delighted to talk to him and I ask him to include mental disorders.

Daniel Francis: I hear that, and I think my hon. Friend and I are on the same page on many of these matters. I think there were some drafting issues when I discussed amendments with Mencap at an earlier stage.

I commend to the Committee the six amendments in my name in this group: new clause 12 and amendments 336, 337, 335, 340 and amendment (a) to amendment 186.

Danny Kruger (East Wiltshire) (Con): I want to quickly indicate my support for the amendments tabled by the hon. Member for Bexleyheath and Crayford, amendment 290 in the name of the hon. Member for York Central and amendment 20 in the name of the hon. Member for Lowestoft about specific training on domestic abuse and coercive control.

I will now speak to my own amendments, which would require there to be a preliminary discussion before the signing of the first form. At the moment, the Bill allows someone to make the first declaration and state, "I wish to be provided with assistance to end my own life", without any preparatory discussion about what that entails. It is significant that we heard evidence from Professor House—a professor of old-age psychiatry—that the preferences of the person doing the assessment can bias the capacity assessment. As he explains, we are much more likely to declare that somebody has capacity when they say they want to have the treatment we are offering them, but can we really be sure that the request is freely made and reflects the patient's wishes?

The fact is, we still do not know from the framework of the Bill how the process would be implemented, but the assessor is likely to be one of a small number of doctors who are willing to do this work on the NHS or somebody who is working for a private provider. Research suggests that the assessing physician's own personal values and opinions may bias their judgment of a person's mental capacity. Effectively, research says that the doctor will say that a person has capacity for treatment when he or she wants them to have it or believes that they should. That is significant.

We see from other jurisdictions that the assessment process can quickly become a tick-box exercise in which proper consideration is not given to what might be going on behind the declared wish. In Oregon in 2023, only three people were referred for a psychiatric evaluation by the assessing doctor—down from 33% of people in the early years. It is clear that evaluators have become less cautious when they come to sign the initial paperwork. In California, less than 1% of patients requesting an assisted death are referred for a mental health assessment. These are significant warning signs for us.

I am aware that the hon. Member for Spen Valley has tabled a helpful amendment—amendment 419—to clause 6, which is the clause dealing with the requirement for proof of identity. As I said yesterday, this retrofits a requirement for a preliminary discussion before the process can proceed. It is good that the hon. Member recognises the point that a proper preliminary assessment must be done before the declaration is signed, but I simply do not understand why that should be in clause 6; surely it should be in one single, consistent place, here in clause 5, relating to when the co-ordinating doctor first meets the patient to witness their form. I hope we might recognise that if the principle is being conceded by the amendment tabled by the hon. Member for Spen Valley, we should put that change into its rightful place.

It is worth nothing that at the moment someone could get a proxy to sign for them. The proxy does not need to know the patient or be known to them; they just need to be a person of good standing in the community. They need to undertake no training at all. We have been talking during in this debate about the importance of training, but the proxy who signs on the patient's behalf does not need to have any training to inform the judgment that they are

"satisfied that the person understands the nature and effect of the making of the declaration".

Frankly, a stranger to the person, who is not a medic, can sign that declaration on their behalf. At the moment, they can do so without a preliminary discussion taking place. It is only after making that crucial declaratory statement that the co-ordinating doctor discusses the person's diagnosis. I welcome the tabling of amendment 419, but I think it is in the wrong place. If we do not ensure that that preliminary discussion takes place when we are debating this group of amendments, it might be too late if amendment 419 does not pass, or if it is unsatisfactory, as I think it is.

There is another related problem. Amendment 419 would allow the co-ordinating doctor to confirm that a preliminary discussion has taken place. That means that the discussion could have taken place before the first declaration—in a sense, that is welcome, because that discussion should be taking place—but it does not have to take place with the co-ordinating doctor. The co-ordinating doctor, who is taking responsibility for the whole process of the assisted death for this patient, is not required to have this preliminary discussion themselves. They are not required to go through the very important process of properly discussing the assisted death and informing the patient of what it entails and what the other options are.

My amendment 359 would enhance the significance of the preliminary discussion. It would mean that the doctor who witnesses the declaration—who co-ordinates the process of the assisted death—has had the fullest possible discussion with the patient, and that they genuinely take responsibility for guaranteeing that the patient is fully informed and aware of all of their options. I urge the Committee to support these amendments as well.

Liz Saville Roberts (Dwyfor Meirionnydd) (PC): I am very glad that amendment 427 has now been unstarred for today, because it develops on what I initiated yesterday with amendment 413, when we were discussing identifying the preferred language of the individual and whether that is Welsh or English.

Of course, if we have identified the preferred language of an individual, we would then take every step to make sure that we satisfy them and that we provide services in their preferred language. The amendment also recognises, when we are talking about specific individuals, possibly in a specific location, whether providing that is possible or not. I have tried to reflect that in using the terminology "all reasonable steps" to ensure that the practitioner has

"fluent proficiency" in Welsh if that is the preferred language of the individual with whom they are conducting the initial conversation. Bear in mind, of course, that practitioners who can hold a conversation with fluent proficiency in Welsh will also be able to hold a conversation with fluent proficiency in English.

The "all reasonable steps" phraseology comes from legislation already extant in Wales in relation to educational tribunals, which again recognise that it may not be possible to find an individual with sufficient proficiency. We are trying to find a balance here between the pressure of time and being able to move ahead without having a bureaucratic thicket while also acknowledging that if we do recognise an individual's preferred language, that we do take "all reasonable steps".

As with amendment 413, amendment 427 is an amendment that I tabled having met an officer from the Welsh Language Commissioner's office last week. It would establish a pathway for people for whom Welsh is their preferred language. Reflecting the comments from the Minister and the Bill's promoter, the hon. Member for Spen Valley yesterday, I need to know—as do the Committee and the Senedd—whether this needs to be on the face of the Bill or whether it could be elsewhere.

I do not intend to push amendment 427 to a vote today, but we very much need clarity on this issue. I suspect that this may not be so easy to clarify as yesterday's point. We are talking about the rights of individuals in one of the most difficult, emotional, intimate discussions of their lives. We need to reflect that those individuals have a clear right to use the language which they have a choice in law to use. We must make sure that we get everything correct in this Bill. Diolch yn fawr iawn.

9.45 am

Naz Shah: I rise to speak to amendment 20, which was tabled by my hon. Friend the Member for Lowestoft (Jess Asato).

The key point for me is that doctors are not specialists in coercive control, but this amendment would give them training to spot abusive and coercive relationships, which are difficult to detect. Domestic abuse and coercive control have a disproportionate effect on women and disabled people, and if doctors just rely on their experience to detect coercive control and abuse, they are more likely to miss cases. Some doctors will be more experienced or more perceptive than others. This amendment is not a perfect safeguard, but it will improve the chances of doctors stopping people being coerced.

The amendment would ensure that co-ordinating doctors must have undertaken training on domestic abuse, including coercive control and financial abuse. It is a significant and distinct amendment. In particular, it addresses the issue of repeated coercive control, which so far has been overlooked in the Bill. I believe that amendments seeking to improve safeguards against coercion that do not address the issue of repeated coercive behaviour are inadequate in protecting vulnerable people, particularly women.

It is regrettable that in our witness sessions we did not hear from any experts on repeat coercive control. Such testimony would have been valuable, helping the Committee to understand why this specific environment puts people at risk with regard to the Bill.

We have already spoken a great deal about coercion in this Committee and other Members have referred to that. We have raised concerns about someone coercing another person into the process of assisted dying in a one-off incident. However, we have not yet discussed the very real issue of repeated coercive control and what it means to live in that environment, nor the implications that the Bill may have for people in those situations.

Dr Hannah Denno submitted written evidence to this Committee. She wrote:

> "As a doctor I am not trained to detect coercion, and I do not believe that the Bill pays sufficient attention to the detection of those who are under pressure from themselves or others to end their lives. The Bill describes two independent medical assessments, both can be carried out by doctors who have never previously met or cared for the patient."

Kim Leadbeater (Spen Valley) (Lab): I just want to provide some reassurance to my hon. Friend the Member for Bradford West. I have met my hon. Friend the Member for Lowestoft and today I will support amendment 20, which she has tabled. I hope that provides some reassurance to my hon. Friend the Member for Bradford West.

Naz Shah: I am grateful to my hon. Friend for that intervention and I am really grateful that she is supporting the amendment. However, the reason I am making this speech is that I do not think the amendment goes far enough in terms of providing safeguards within the Bill. So, I will make some progress with my speech and then I will address some of the issues that are not addressed in this particular amendment, and set out how we can go further, as well as highlighting some of my concerns.

I return to what Dr Denno wrote in the evidence that she submitted. She wrote that she was:

"not trained to detect coercion".

And she also wrote that

> "Social workers are better placed to screen for coercion but are not mentioned in the Bill."

Since that submission, my hon. Friend the Member for Spen Valley has tabled an amendment that would mandate a social worker to sit on a panel to consider each application for assisted death. However, I am afraid that I must repeat several points about these panels, points that have already been made frequently. These panels are under no obligation to interview the applicant for assisted death in person. Panel members may do so if they have any concerns, but they may not. That makes it harder for panel members to detect possible coercion.

There is also an absence of any mechanism for people who know assisted dying applicants to report any concerns they have that that person is being coerced into this form of action. The panels are not used in that way, which is the way that multidisciplinary panels are used in the NHS to decide on the pathway for a patient. Instead, the panels introduced by my hon. Friend's amendment would wait until the two doctors have submitted their statements on the applicant and then the panel members would scrutinise those statements. If they spot problems with the way that the doctors have determined that the patient is not being coerced, then, yes, they would call the patient in for more scrutiny. However, they will first have to come to that conclusion without seeing the patient. That is not a very robust safeguard.

Kim Leadbeater: I am in the process of tabling an amendment that would change the panel to that effect, so that it would speak to the patient. Hopefully, that provides some more reassurance for my hon. Friend. I am sure that we are working very effectively through the Committee process to achieve what we all want to see.

Naz Shah: I am pleased to hear that my hon. Friend will table further amendments, but I have not seen that amendment, so I cannot speak to it.

I would slightly beg to differ with my hon. Friend in terms of making progress in the way that I would like to have seen. I would just gently remind her that I am not convinced that we are. I think we are making good progress, but I also voted against one clause stand part and had lots of concerns about another one, so we will agree to disagree on that one.

The non-governmental organisation The Other Half observes in its written evidence to this Committee—TIAB 104—that the Bill makes no provision to identify family members who may benefit financially from the death of a patient, and, therefore, the Bill is unable to protect the vulnerable. That is something that I have said before in this Committee.

This amendment makes training in respect of financial abuse mandatory. It is vital that a medical practitioner is trained on how to identify coercion—we can all agree on that—but coercion is different from domestic abuse. Coercion may be relatively obvious to spot, but, in contrast, coercive and controlling behaviour is much less obvious. It can be subtle. It can be hidden, and unexpected to an outsider. It requires much more sensitive questioning and a degree of a doctor-patient relationship to identify. Multiple people have raised that a patient-doctor relationship is important for spotting that, and, currently, there is nothing in the Bill to say that the two independent doctors have to have met the patient before.

That subtle coercion could have happened over years. We have repeatedly heard from people giving evidence that it is really hard to spot, and the reason it is hard to spot is because it is a matter of trust for a patient to be able to tell somebody—for a victim of coercive control to be able to express that. Even recognising that there is subtle coercion going on is hard for victims of that coercion to understand.

If there is domestic violence—again, I say in this Committee that I first campaigned on domestic abuse in the mid-1990s, and I am not convinced that the stats have changed much. I will refer to some more later on, as I make progress, but it takes women, on average, 40 times to leave an abusive partner—40 times—and it took me a long time to leave my abusive forced marriage when I was very young. The coercion that happens is so subtle and, again, when it is repeated coercion, it is hard to even recognise it as a victim, let alone for a professional to be able to see it. Even when a professional may pick up on it, it is acknowledgment from the victim—that they recognise what is happening—that is important, and that often is not the case.

Again, multiple people have raised that the doctor-patient relationship is important, and there is nothing currently in the Bill to ensure that there is a long-standing relationship between the doctor and the patient. Therefore, it is unreasonable to assume that someone in an abusive relationship, or who experiences coercive and controlling behaviour on top of their terminal illness, would be willing and able to disclose that to a stranger, even if that stranger is a doctor.

On top of that, research suggests that a significant proportion of medical staff in the UK do not feel that they have had adequate training to spot domestic abuse. Research by YouGov and the charity SafeLives in 2018-19 found that half of UK healthcare professionals are untrained to spot domestic abuse.

I understand the current difficulty in ensuring that doctors have a prior relationship with patients; it may not be practically possible. In many cases, where patients will know their doctors, or even know them well, it is even more vital that both doctors have been thoroughly trained in spotting coercive-control behaviour.

Like the other Labour MPs on the Committee, I was elected on a manifesto pledge to halve violence against women and girls within the next 10 years. We must not forget that as we scrutinise this legislation; I want my colleagues and I to remain committed to that in this Bill.

This Bill will have particularly grave consequences for women, since we know that domestic abuse disproportionately affects them. The crime survey for England and Wales estimated that 2.3 million people aged 16 years and over experienced domestic abuse in the year ending March 2024. Of those, 1.6 million were women and 712,000 were men. In the same year, there were only 51,183 domestic abuse-related prosecutions—a very small number compared with the number of people who experienced domestic abuse. That is in addition to the abuse of our elderly, on which Age Concern submitted evidence. Those figures demonstrate that we already frequently struggle with bringing domestic abuse cases to prosecution stage. They show that even the dedicated members of our caring professions have trouble detecting domestic abuse. If something is hard, we need to train our doctors to do it.

Our society already diminishes the status of elderly, infirm women and I have concerns that the Bill will further entrench that. We need to be aware of and ensure that we address the problem of mercy killings in the Bill. That issue is distinctly gendered and the Bill as currently worded will have a distinctly gendered impact if we do not address it. In 2024, The Other Half carried out a review of more than 100 UK cases of so-called mercy killings. It found that

> "'mercy killings' are not the wanted, 'hastened' deaths that need assisted dying."

Instead, the review found that:

> "They are overwhelmingly violent domestic homicides of women, by men: and show that our society is still poor at detecting and responding to domestic abuse."

Some groups are more vulnerable to domestic abuse than others. A higher proportion of people aged 16 and over with a disability—a group that we know is vulnerable in relation to the Bill—experienced domestic abuse in the last year than those without a disability.

The law and Parliament have, unfortunately, taken a very long time to even start adequately responding to these problems. Coercive control was first recognised as a distinct offence in English law only in the Serious Crime Act 2015. As written, the Bill would not mandate training to the doctors whose role it would be to consider assisted dying cases. Of course, no training can be perfect, but to allow the Bill to go forward without

ensuring that doctors have training in this complex matter would be negligent. It would mean that we were failing to even try to carry out our responsibilities to protect people, especially women, in abusive and coercive relationships.

I appreciate that my hon. Friend the Member for Spen Valley has said that she will accept the amendment, but it does not go far enough. The question is: how do we prevent abusers making use of the Bill if it becomes law? The amendment gives us one way of mitigating that risk to a degree. We already have issues recognising domestic abuse. The amendment cannot perfectly solve that problem, but it would take steps to do so.

We must safeguard vulnerable people who live subject to coercive and controlling behaviour on a daily basis from opting for assisted dying as a result of that environment. Thorough and specific training on spotting that is vital for doctors. I am grateful that my hon. Friend, in accepting the amendment, will ensure that some of that training will be forthcoming. Even one abused person being driven by their abuser to use assisted dying is one too many. I am confident that all hon. Members would agree with me on that deeply important point.

In the last few days, I have been looking at suicide, and one of the issues that has come up is that last year, for the first time in our history, suicide by victims of domestic violence overtook deaths from what we would term intimate partner homicide. In the last two weeks, there have been further reports highlighting that the number of women driven to suicide because of the experience of domestic violence has risen. Tomorrow, my hon. Friend the Member for Birmingham Yardley (Jess Phillips) will read the name of every woman who has been killed in the last year, as she does every year. Two of those women were my constituents, and many more kill themselves to get away from their abusers.

The Chair: Order. I understand where the hon. Member is coming from, but I think she is very close to moving outside the scope of the amendment, so can I ask her to bear that in mind? As I have said, this is a very sensitive issue and I am giving people latitude, but that cannot go too far. I do not want to interrupt Members, but I will if they do not stick to the confines of the amendment.

10 am

Naz Shah: I am grateful, Mr Dowd. I will bring my remarks back to the issue in the amendment, which is related to training. I will also bring them back to the issue of interpreters.

In November 2023, the Imkaan group issued a report, "Life or Death?" It literally is a matter of life and death. The report talked about the use of interpreters, training and minoritised women. Imkaan said that

> "The availability and use of quality interpreting services can be critical to women's access to safety and protection"

and that the current position on police use of interpreters breaches the Equality Act and amounts to indirect discrimination. It also breaches the commitments under the Istanbul convention. I appreciate that that issue is about police training, but surely the principles are exactly the same. We have a service—the police and domestic violence services—which supports victims of coercive control and of domestic violence. Unfortunately they come into contact with it, as our NHS and our medics do, way too often for my liking.

The Chair: Order. The issue of interpreters is not within this group. I am just trying to look for that and it is not in this group, so I am afraid the hon. Lady is out of scope of the clause. It is in a later group, so perhaps she could pick it up then.

Naz Shah: I thank you, Mr Dowd. My apologies. I have made a mistake, but I was referencing the comments of the right hon. Member for Dwyfor Meirionnydd about the use of languages, which is the subject of one of the amendments; that is my understanding. But again, I am happy to be guided by you, Mr Dowd.

To come back to the issue of training and domestic violence, in Committee, we heard evidence from Dr Jamilla Hussain about minoritised women. Again, from the data collection of ethnic minority groups, training is right at the top of the agenda, whether it be training of doctors or specialists.

Language is important when it comes to training as well. When people are training or trained to look at coercive control and to spot that coercive control, there is often an interpreter between them and the victim who is being assessed. They may be an ethnic minority woman or a man from an ethnic minority background whose first language is not English, so that training would need to include cultural sensitivities in relation to spotting coercion and control, and to repeated coercion in particular.

These are subjects that are already taboo for people to discuss. We know the issue of domestic violence is hard to spot. We have repeated that time and again, as have others. We talk about training, but that has to go further when it comes to victims or people seeking assisted dying who are from ethnic minority backgrounds and who have different cultural understandings. I talked about yesterday that. The hon. Member for Reigate also talked about the issue: the understanding of assisted dying among ethnic minority communities is very different if there is a language barrier.

I would like to ask the promoter of the Bill, my hon. Friend the Member for Spen Valley, whether her amendment will go further in addressing some of the inequalities and intricacies that are presented when we are dealing with women from ethnic minority communities or elderly people from ethnic minority communities. I would be happy to sit down and talk her through those issues, so that I can support the development of her amendment to address the concerns I have raised today.

Danny Kruger: The hon. Lady talked earlier about the tragedy of victims of coercive control who commit suicide. Does she consider that the amendments we are looking at will help to address that challenge? What specific support does she think victims of coercive control would need to prevent them from taking that terrible step?

Naz Shah: The hon. Member asks a very important question. When I am talking about reflective services for black and minority ethnic communities, which is something I have delivered training on and worked on in a previous role, I often use the example of my mother, who was a victim of domestic violence. Had she been arrested by a woman instead of a man, her experience might have been different. Had she had a solicitor who was a woman, not a man, her experience might have

[Naz Shah]

been different. Had she had judges who were women, not men, her experience might have been different. Let us now add another layer to that. Had the police officer been a woman from the background she was from, they might have understood it.

The same analogy potentially applies to patients who are asking about going down the route of assisted dying, because it is helpful if somebody comes from the same cultural background. If a female victim of domestic violence or coercive control meets a specialist doctor who looks very similar to the hon. Member for East Wiltshire—a white, middle-class male—and he does not have that cultural understanding, he will then rely upon training, and he will no doubt rely upon an interpreter to translate.

That is the kind of thing I am trying to tease out, and these are the kinds of protections I want to see in the Bill. If we want a Rolls-Royce service, and if this is to be the best Bill in the world, it cannot ignore the most vulnerable in society. If the patient is a disabled woman, it is whammy upon whammy and layers upon layers of intersectionality that the Bill does not address. That is why I want to see the Bill strengthened.

I want to talk about the training that doctors get and the training in palliative care. We heard from Dr Jamilla Hussain, who was very clear about the fear among minoritised communities because of what happened during the covid pandemic, with "do not resuscitate" orders and their whole experience. Some people potentially died who could have been saved because they did not have the trust in NHS services to access them.

In this instance, it is important that we have a first doctor. That first doctor might have no relationship with the patient because their regular doctor does not want to engage in the process. Let us take the example of a patient in Bradford West who has had a diagnosis of terminal illness. They might well have a doctor or consultant who has been dealing with them for six months or even a year, to the point where they have reached the terminal stage. They might have a relationship with that doctor, who might have spoken their language and might be from a particular faith background but who does not want to engage in the assisted dying process. According to the Bill, that doctor would then have to refer that patient on to somebody who is prepared to have that conversation, but that person might not have that training or those language skills, and they might not—

The Chair: Order. The hon. Lady needs to keep her remarks to amendment 20. I have looked at other amendments to which this is relevant, including amendment 186, but that has been starred. I exhort the hon. Lady to focus on the particular issues covered by amendment 20.

Naz Shah: Thank you, Mr Dowd. My understanding is that this all relates to amendment 20, and I am happy to clarify why. Ultimately, this is about the professional's intervention with a patient, and the amendment is about training people adequately to assess coercive control and domestic violence. I am trying to demonstrate—I accept that I might not be doing it well enough—that there is a pathway and a catalogue of things that relate back to the person who is being assessed. I am trying to explain to the Committee in detail, because I feel very strongly about it, what that care pathway might look like for somebody, and why the amendment, although I welcome it, does not safeguard the most vulnerable in society. I am happy to be guided if that is not what I am doing, but that is certainly what I am attempting to do. May I carry on, Mr Dowd?

The Chair: The hon. Lady should take this in the spirit in which it is intended. Dipping in and out of issues throughout the course of a speech is okay, but I am afraid that dipping in and out of issues that are not relevant is not, and we are getting to the stage where the information she is imparting is not necessarily relevant, in significant elements, to the amendments that we are dealing with.

Naz Shah: Thank you, Mr Dowd. I would argue otherwise. I would say that actually, every single—

The Chair: Order. My ruling from the Chair cannot be challenged. I exhort the hon. Lady to stick to the amendments before us. If she does not, I will have no other option but to intervene and move the debate on.

Naz Shah: Thank you, Mr Dowd.

I come back to the issue of potential coercive control, which is what amendment 20 addresses. As I have outlined, there are patients who could be in that position. Given the examples that I have put before the Committee, I argue that the amendment, although it is brilliant in getting us to a better place than where we started out with the Bill—I am pleased that my hon. Friend the Member for Spen Valley has indicated that she is happy to discuss strengthening the safeguards—does not go far enough, for the very reasons that I have outlined, and no doubt will outline further when speaking to other amendments.

The Minister for Care (Stephen Kinnock): It is a pleasure to serve under your chairship, Mr Dowd. As I have said, the Government remain neutral and my role is not to offer a Government view on the merits of the amendments, but to provide a factual explanation of their technical and practical effect to assist the Committee in its scrutiny.

The Government remain committed to ensuring the legal robustness and workability of all legislation, so I have worked closely with my hon. Friend the Member for Spen Valley on some amendments. Where changes have been mutually agreed by my hon. Friend and the Government, I will offer a technical, factual explanation and rationale for the amendments. Those include amendments 185 and 186 in this group. The Government remain neutral on the Bill and do not have a position on assisted dying.

This group relates to the necessary training, qualifications and experience of the co-ordinating doctor. As drafted, clause 5 gives the Secretary of State the power to specify the training, qualifications and experience required for a registered medical practitioner to act as a co-ordinating doctor, but there is no legal duty for the Secretary of State to do so. Amendments in this group either seek to change that power to a legal duty, or would introduce specific training, qualifications and experiential requirements for a registered medical practitioner to act as a co-ordinating doctor.

Amendments 185 and 186 tabled by my hon. Friend the Member for Spen Valley would introduce a duty on the Secretary of State to make regulations regarding the necessary training, qualifications and experience of the co-ordinating doctor. Giving the Secretary of State a duty rather than merely a power would ensure certainty as to the training, qualifications and experience that the registered medical practitioner must have in order to act as a co-ordinating doctor. The Secretary of State's duty in this respect would include making provision in regulations about training for co-ordinating doctors relating to assessing capacity and assessing whether a person has been coerced or pressured by another person. Amendment 186 would also enable the Secretary of State, subject to the specific training requirements already mentioned, to delegate the determination of the training, qualifications and experience needed for a co-ordinating doctor to a person specified in the regulations. That would allow that determination to be delegated to a body or bodies with appropriate expertise, in line with other aspects of training for healthcare professionals.

10.15 am

It is understood that amendment (a) to amendment 186 seeks to add to the duty, just outlined, related to regulations to be made by the Secretary of State on training, qualifications and experience. The amendment would require the regulations to specify up-to-date training on reasonable adjustments and safeguards for autistic people and people with a learning disability. When deciding whether the amendment is required, Committee members may wish to know that the Health and Care Act 2008 requires that all Care Quality Commission-registered health and adult social care providers must ensure that their staff receive specific training about learning disability and autism. That training must be appropriate to the staff member's role, to ensure that they have the right knowledge and skills to provide safe and informed care.

Amendment 290 specifies that physician associates, doctors in training grades, doctors in postgraduate training and doctors working in locum positions would not be able to act as a co-ordinating doctor. Physician associates are already excluded under the Bill from acting as co-ordinating doctors as they are not registered medical practitioners. The operational impact of the amendment in respect of excluding doctors in training grades, doctors in postgraduate training and doctors working in locum positions would be to limit the registered medical practitioners who could undertake the role of the co-ordinating doctor to a subset of registered medical practitioners.

Amendments 335 to 337 require that regulations on the training for registered medical practitioners to act as a co-ordinating doctor or independent doctor would need to specify that that training be specialised. Putting that requirement into the Bill might limit the nature of the training that could be specified in the regulations and guide those charged with framing such requirements to more specialised requirements relating to provisions of assistance under the Bill.

New clause 12 would make it clear that a registered medical practitioner or other health professional was not under any duty to participate in training wholly or largely related to the provision of assisted dying services, or to provide assisted dying services even if they had carried out such training. On both aspects of the new clause, I draw the Committee's attention to the existing provision in clause 23, which states:

> "No registered medical practitioner or other health professional is under any duty…to participate in the provision of assistance in accordance with"

the Bill. That right to opt out would not be impacted by the training that a medical practitioner had undertaken.

Amendment 52 places the Secretary of State under a duty to make regulations about the necessary training, qualifications and experience of the co-ordinating doctor rather than merely having a power to do so. Such regulations would also need to include experience of managing terminal illnesses. A requirement rather than a power to make regulations on training, qualifications and experience will ensure that there is certainty about the training, qualifications or experience that a registered medical practitioner must have to act as co-ordinating doctor. That change has been proposed through amendments 185 and 186. Requiring that the regulations specify experience of managing terminal illness may limit the number of registered medical practitioners able to act as a co-ordinating doctor. Putting that requirement into the Bill might have the operational impact of limiting the options that could be explored in the development of a training programme.

Amendment 359 would require the co-ordinating doctor to be the same person as the registered medical practitioner conducting a preliminary discussion under clause 4. The amendment would have the additional effect of requiring the registered medical practitioner who undertook the initial discussion to have met the specific training requirements and qualifications that the co-ordinating doctor will need to have met. That could have the effect of limiting the numbers of registered medical practitioners that can undertake the preliminary discussions.

Danny Kruger: Will the Minister clarify that point? Is he suggesting that because fewer doctors might be eligible or willing to conduct the preliminary assessment, we should not require it at that early stage?

Stephen Kinnock: What we are trying to say is that the important thing here is to ensure that, when the Secretary of State brings the regulations forward, the hands of the Secretary of State are not tied too tightly, so that the Secretary of State is able to bring together the right people, to deliver the right training, to achieve the outcomes that are required through the regulations. Our assessment is that this amendment would, in essence, narrow the pool of people available to do the training. That would seem to pre-empt the idea behind doing this through regulations, which is to ensure that there is up-to-date training that is responsive to where we may or may not be two years down the line from the Bill having its commencement. It is about having that flexibility and that ability to build capacity.

Amendment 340 would place the Secretary of State under a duty to make regulations requiring a co-ordinating doctor to have specific and up-to-date training relating to reasonable adjustments and safeguards for autistic people and people with a learning disability. I note that amendments 185 and 186, if passed, would impose a duty on the Secretary of State to specify the training, qualifications and experience that the co-ordinating doctor will need.

[Stephen Kinnock]

The consequence of this amendment would be to require the Secretary of State to introduce a further requirement on the co-ordinating doctor—to have undergone training relating to reasonable adjustments and safeguards for autistic people and people with a learning disability. In considering whether the amendment is required, I note that the Health and Social Care Act 2008 requires that all CQC-registered health and adult social care providers ensure that their staff receive specific training on learning disability and autism.

Amendment 427 would impose an obligation to take all reasonable steps to ensure that the co-ordinating doctor is proficient in the Welsh language if services or functions under this legislation are to be provided to an individual in Welsh in Wales. The amendment does not make it clear who would be obliged to ensure that those steps were taken, or who would assess and enforce whether the "fluent proficiency" standard was met.

Liz Saville Roberts: What the Minister is referring to is the appropriate authorities, because areas related to training and regulation of registered practitioners in Wales are devolved to the Welsh Government. I will be touching on that later, but I would beg him to approach the amendment in that spirit.

Stephen Kinnock: I know that we are coming on to the question of appropriate authorities and I absolutely see and understand the spirit in which this amendment is suggested. The challenge is just about the potential for it to lead to operational issues, such as a reduced pool of registered medical practitioners who are able to carry out the function of a co-ordinating doctor under this legislation.

Liz Saville Roberts: That is exactly why the amendment includes a reference to "all reasonable steps". It is with that in mind. This is reflected in other legislation where similar concerns have been expressed.

Stephen Kinnock: I thank the right hon. Lady for that. We go back to the point about the true significance of the 2011 Welsh Government Measure, which sets a basic foundation for the duty of the Welsh Government to ensure that Welsh language provision is provided through the Welsh NHS. There is absolutely no debate about that point; that is nailed on. The question is simply how we ensure, if we are to amend this Bill along the lines that the right hon. Lady suggests, that that does not create a lacuna or confusion in the system. I think we need to sit down and discuss that, to ensure that whatever we propose is watertight.

It may be helpful to note, as in discussion of amendment 413, that regardless of this amendment, under the Welsh Language Measure of 2011 the NHS in Wales has a statutory duty to deliver its services to the public in both Welsh and English. That legislation gives the Welsh language official status in Wales, and the Measure states that individuals in Wales should be able to conduct their lives through the medium of Welsh if they choose to do so. The Welsh Government's active offer for health is intended to support all staff across NHS Wales to provide a service in Welsh for patients without their having to ask for it.

Under amendment 20, regulations made by the Secretary of State on the necessary training, qualifications and experience of the co-ordinating doctor would be required to include mandatory training relating to domestic abuse, including coercive control and financial abuse. Amendments 185 and 186, tabled by my hon. Friend the Member for Spen Valley, would require that regulations made by the Secretary of State on the necessary training, qualifications and experience of the co-ordinating doctor covered training related to assessing capacity and whether a person has been coerced or pressured by another person. But I note that, as my hon. Friend the Member for Spen Valley has said, she is minded to support amendment 20, which clearly would ramp up the requirement, as previously discussed.

As I have said, the Government have taken a neutral position on the substantive policy questions relevant to how the law in this area could be changed, but to clarify the intent of the Bill, we have worked with my hon. Friend the Member for Spen Valley in relation to amendments 185 and 186, which would place the Secretary of State under a duty to make regulations regarding the necessary training, qualifications and experience of the co-ordinating doctor. That would include specific training on assessing capacity and assessing whether a person has been subject to coercion or pressure.

I hope that that explanation and those observations have assisted the Committee. I thank hon. Members for their attention.

Kim Leadbeater: I rise to speak first to my amendments 185 and 186, which would make important changes to impose a duty on the Secretary of State to make regulations about the training, qualifications and experience required to act as the co-ordinating doctor, as the Minister says. Moving from "may" to "must" would make it a legal requirement that such training take place and would thereby strengthen the Bill. In its present form, the Bill gives the Secretary of State that power to make such regulations but does not legally require him or her to do so.

Amendment 186 would ensure that regulations must include training about

"(a) assessing capacity;

(b) assessing whether a person has been coerced or pressured by any other person."

Colleagues will appreciate that it is difficult for me to resist the temptation to put the entire training manual in the Bill—we all want to show the thorough approach that has been taken—but doing so would not make for good, clear legislation and can be limited in terms of flexibility and future-proofing. However, given the importance of the matters of capacity and coercion, I felt that it was important that this level of detail be specified in the Bill, because those issues have been at the heart of so many of our deliberations on this hugely sensitive and important issue.

My hon. Friend the Member for Bexleyheath and Crayford, who tabled amendment (a) to my amendment 186, has made a compelling argument, as always. Like my hon. Friend the Member for Penistone and Stocksbridge, I have some concerns that the amendment would limit the number of disabled people who are covered and that it would not cover people with mental disorders, but I understand the concerns around autistic people and those with learning disabilities.

I am also mindful, given that people with Down's syndrome will typically have some form of learning disability, that amendment (a) may help to address some of the concerns that were expressed yesterday about ensuring that the Bill meets their needs and takes them into consideration. I take on board the Minister's comments about the Health and Care Act 2022, but I am minded to support the amendment and work with my hon. Friend the Member for Bexleyheath and Crayford and others as necessary to make any further changes as the Bill progresses.

Jack Abbott (Ipswich) (Lab/Co-op): I am grateful to my hon. Friend for supporting that amendment. We have often debated the level of detail that should be set out in the Bill. I fully appreciate that she does not want to include the whole training manual; I will not discuss my amendment, which concerns culture and trauma-informed care, because I recognise that it is much too detailed in that respect. However, does she agree that where possible, and where it does not create unintended consequences or loopholes, we should reassure not just colleagues across the House but members of the public, who want to see these sorts of thing on the face of the Bill?

Kim Leadbeater: My hon. Friend is absolutely right. If the Bill passes, it will be a huge change. We have a duty to the public to show that we are including sufficient detail in the Bill and to provide reassurance in any way we can. To be honest, I would quite like to put the entire training manual in the Bill, but I appreciate that from a legislative perspective that is not possible. However, there are occasions when, for the avoidance of doubt, we should make certain provisions clear on the face of the Bill.

That brings me to amendment 20, which was tabled by my hon. Friend the Member for Lowestoft, who has a huge amount of experience and expertise in the field to which it relates. Her amendment states:

"Regulations under subsection (3)(a) must specify that training in respect of domestic abuse, including coercive control and financial abuse is mandatory."

At the moment, there are no safeguards for terminally ill victims of domestic abuse, financial abuse or coercive control. That concerns me, and it feeds into the points made by my hon. Friend the Member for Bradford West.

If a victim of domestic abuse or coercive control—it is often a woman, as we know—is also terminally ill, I can only imagine what a lonely place that is. At the moment, that person is under no supervision. Sadly, there have been instances in which those people have taken their own life. They will continue to be the victims of their incredibly difficult personal circumstances on top of having a terminal illness, which is an absolute tragedy. Opening up the conversation with doctors and healthcare professionals about their circumstances has to be a good thing. It will shed light and transparency on what must be an incredibly difficult situation.

10.30 am

Amendment 20 would require the registered medical practitioner acting as the co-ordinating doctor to have undertaken important detailed training on domestic abuse, including coercive control and financial abuse. I think that that would enhance those very difficult conversations. I have met with my hon. Friend the Member for Lowestoft and I know how passionately she feels about the issues, as I and many other colleagues do. I have taken our conversations very seriously and will be meeting her again next week, along with a number of organisations that specialise in domestic abuse and coercive control, to discuss their thoughts on the Bill. I am pleased to support the amendment.

I turn to amendment 340, which stands in the name of my hon. Friend the Member for Bexleyheath and Crayford. My understanding is that if we support amendment 186, as amended by amendment (a), it will not be necessary to support amendment 340, because they would essentially do the same thing.

On new clause 12 and the amendments related to it, I take on board the Minister's comments about the possible consequent limits on training. I concur with his point that the new clause is not necessary, even though I understand the sentiment behind it, because clause 23 is already very clear that there is no obligation on medical practitioners or health professionals to provide assistance.

On amendment 427, I think we covered the relevant points yesterday. As I have said, I am very open to continuing the conversations to ensure that the Welsh language is fully respected in the Bill.

Jack Abbott: On a point of order, Mr Dowd. I think my hon. Friend the Member for Spen Valley said that if amendment (a) and amendment 186 are agreed to, that will negate the need for amendment 340. I seek clarity on whether that is the case.

The Chair: It is not for me to make that decision.

Naz Shah: I wish to divide the Committee on amendment 290.

Question put, That the amendment be made.

The Committee divided: Ayes 9, Noes 13.

Division No. 31]

AYES

Abbott, Jack	Olney, Sarah
Campbell, Juliet	Paul, Rebecca
Francis, Daniel	Shah, Naz
Joseph, Sojan	Woodcock, Sean
Kruger, Danny	

NOES

Atkinson, Lewis	Opher, Dr Simon
Charalambous, Bambos	Richards, Jake
Green, Sarah	Sackman, Sarah
Hopkins, Rachel	Saville Roberts, rh Liz
Kinnock, Stephen	Shastri-Hurst, Dr Neil
Leadbeater, Kim	Tidball, Dr Marie
Malthouse, rh Kit	

Question accordingly negatived.

Amendment made: 185, in clause 5, page 3, line 14, leave out from "who" to end of line 15 and insert

"meets the requirements specified in regulations under subsection (3A)".—*(Kim Leadbeater.)*

This amendment and Amendment 186 impose a duty on the Secretary of State to make regulations about the training, qualifications and experience required in order to act as the coordinating doctor.

Amendment proposed: 335, in clause 5, page 3, line 14, after "such" insert "specialised". —*(Daniel Francis.)*

This amendment is linked with NC12.

Question put, That the amendment be made.

The Committee divided: Ayes 8, Noes 14.

Division No. 32]

AYES

Campbell, Juliet	Olney, Sarah
Francis, Daniel	Paul, Rebecca
Joseph, Sojan	Shah, Naz
Kruger, Danny	Woodcock, Sean

NOES

Abbott, Jack	Malthouse, rh Kit
Atkinson, Lewis	Opher, Dr Simon
Charalambous, Bambos	Richards, Jake
Green, Sarah	Sackman, Sarah
Hopkins, Rachel	Saville Roberts, rh Liz
Kinnock, Stephen	Shastri-Hurst, Dr Neil
Leadbeater, Kim	Tidball, Dr Marie

Question accordingly negatived.

Liz Saville Roberts: I beg to move amendment 144, in clause 5, page 3, line 14, leave out "Secretary of State" and insert "appropriate authority".

This amendment has the effect of allowing the Welsh Ministers to make regulations under Clause 5(3)(a) (training, qualifications and experience of coordinating doctors). A linked amendment to Clause 40 defines appropriate authority to mean the Secretary of State in relation to England and the Welsh Ministers in relation to Wales.

The Chair: With this it will be convenient to discuss the following:

Amendment 145, in clause 5, page 3, line 24, leave out "Secretary of State" and insert "appropriate authority".

This amendment has the effect of requiring the Welsh Ministers to consult regarding the making of regulations under Clause 5(3)(a) (training, qualifications and experience of coordinating doctors). A linked amendment to Clause 40 defines appropriate authority to mean the Secretary of State in relation to England and the Welsh Ministers in relation to Wales.

Amendment 146, in clause 6, page 3, line 34, leave out "Secretary of State" and insert "appropriate authority".

This amendment has the effect of allowing the Welsh Ministers to make regulations under Clause 6(3) (forms of proof of identity). A linked amendment to Clause 40 defines appropriate authority to mean the Secretary of State in relation to England and the Welsh Ministers in relation to Wales.

Amendment 147, in clause 8, page 5, line 13, leave out "Secretary of State" and insert "appropriate authority".

This amendment has the effect of allowing the Welsh Ministers to make regulations under Clause 8(6)(a) (training, qualifications and experience of second doctors). A linked amendment to Clause 40 defines appropriate authority to mean the Secretary of State in relation to England and the Welsh Ministers in relation to Wales.

Amendment 148, in clause 8, page 5, line 28, leave out

"Secretary of State must consult such persons as the Secretary of State"

and insert

"appropriate authority must consult such persons as the appropriate authority".

This amendment has the effect of requiring the Welsh Ministers to consult regarding the making of regulations under Clause 8(6)(a) (training, qualifications and experience of second doctors). A linked amendment to Clause 40 defines appropriate authority to mean the Secretary of State in relation to England and the Welsh Ministers in relation to Wales.

Amendment 149, in clause 11, page 7, line 13, leave out "Secretary of State" and insert "appropriate authority".

This amendment has the effect of allowing the Welsh Ministers to make regulations under Clause 11(1) (replacing the coordinating doctor on death etc). A linked amendment to Clause 40 defines appropriate authority to mean the Secretary of State in relation to England and the Welsh Ministers in relation to Wales.

Amendment 150, in clause 19, page 13, line 21, leave out "Secretary of State" and insert "appropriate authority".

This amendment has the effect of allowing the Welsh Ministers to make regulations under Clause 19(2)(b) (training, qualifications and experience of other doctors). A linked amendment to Clause 40 defines appropriate authority to mean the Secretary of State in relation to England and the Welsh Ministers in relation to Wales.

Amendment 151, in clause 19, page 13, line 31, leave out

"Secretary of State must consult such persons as the Secretary of State"

and insert

"appropriate authority must consult such persons as the appropriate authority".

This amendment has the effect of requiring the Welsh Ministers to consult regarding the making of regulations under Clause 19(2)(b) (training, qualifications and experience of other doctors). A linked amendment to Clause 40 defines appropriate authority to mean the Secretary of State in relation to England and the Welsh Ministers in relation to Wales.

Amendment 152, in clause 20, page 13, line 35, leave out "Secretary of State" and insert "appropriate authority".

This amendment has the effect of allowing the Welsh Ministers to make regulations under Clause 20(1) (meaning of "approved substance"). A linked amendment to Clause 40 defines appropriate authority to mean the Secretary of State in relation to England and the Welsh Ministers in relation to Wales.

Amendment 153, in clause 28, page 17, line 3, leave out "Secretary of State" and insert "appropriate authority".

This amendment has the effect of allowing the Welsh Ministers to make regulations under Clause 28(1) (prescribing, dispensing, transporting etc of approved substances). A linked amendment to Clause 40 defines appropriate authority to mean the Secretary of State in relation to England and the Welsh Ministers in relation to Wales.

Amendment 154, in clause 30, page 18, line 12, leave out "Secretary of State" and insert "appropriate authority".

This amendment has the effect of allowing the Welsh Ministers to make a Code of Practice in Wales under Clause 30. A linked amendment to Clause 40 defines appropriate authority to mean the Secretary of State in relation to England and the Welsh Ministers in relation to Wales.

Amendment 155, in clause 30, page 18, line 31, leave out "Secretary of State" and insert "appropriate authority".

This amendment is linked to an amendment that allows the Welsh Ministers to make a Code of Practice in Wales under Clause 30. A linked amendment to Clause 40 defines appropriate authority to mean the Secretary of State in relation to England and the Welsh Ministers in relation to Wales.

Amendment 156, in clause 30, page 18, line 33, leave out

"Secretary of State must consult such persons as the Secretary of State"

and insert

"appropriate authority must consult such persons as the appropriate authority".

This amendment has the effect of requiring the Welsh Ministers to consult regarding the making a Code of Practice for Wales under Clause 30. A linked amendment to Clause 40 defines appropriate authority to mean the Secretary of State in relation to England and the Welsh Ministers in relation to Wales.

Amendment 157, in clause 32, page 19, line 21, leave out "Secretary of State" and insert "appropriate authority".

This amendment has the effect of allowing the Welsh Ministers to make regulations under Clause 32(1) (powers to ensure assistance is available). A linked amendment to Clause 40 defines appropriate authority to mean the Secretary of State in relation to England and the Welsh Ministers in relation to Wales.

Amendment 158, in clause 32, page 19, line 22, leave out "Secretary of State" and insert "appropriate authority".

This amendment is linked to an amendment that allows the Welsh Ministers to make regulations under Clause 32(1) (powers to ensure assistance is available). A linked amendment to Clause 40 defines appropriate authority to mean the Secretary of State in relation to England and the Welsh Ministers in relation to Wales.

Amendment 159, in clause 33, page 19, line 34, leave out "Secretary of State" and insert "appropriate authority".

This amendment has the effect of allowing the Welsh Ministers to make regulations under Clause 33(1) (notifications to Chief Medical Officers). A linked amendment to Clause 40 defines appropriate authority to mean the Secretary of State in relation to England and the Welsh Ministers in relation to Wales.

Amendment 160, in clause 33, page 20, line 16, leave out "Secretary of State" and insert "appropriate authority".

This amendment has the effect of allowing the Welsh Ministers to make regulations under Clause 33(2)(h) (notifications to Chief Medical Officers: notifiable events). A linked amendment to Clause 40 defines appropriate authority to mean the Secretary of State in relation to England and the Welsh Ministers in relation to Wales.

Amendment 161, in clause 35, page 21, line 30, leave out "Secretary of State" and insert "appropriate authority".

This amendment has the effect of requiring the Welsh Ministers to review the operation of the Act in relation to Wales. A linked amendment to Clause 40 defines appropriate authority to mean the Secretary of State in relation to England and the Welsh Ministers in relation to Wales.

Amendment 162, in clause 35, page 21, line 35, at end insert

"or the Senedd Cymru (as the case may be)".

This amendment has the effect of requiring a review carried out by the Welsh Ministers under Clause 35 to be laid before the Senedd.

Amendment 163, in clause 35, page 22, line 8, leave out "Secretary of State" and insert "appropriate authority".

This amendment is linked to an amendment that requires the Welsh Ministers to review the operation of the Act under Clause 35.

Amendment 164, in clause 37, page 22, line 30, leave out "Secretary of State" and insert "appropriate authority".

This amendment has the effect of allowing the Welsh Ministers to make regulations under Clause 37(1) (modification of form of declarations and statements). A linked amendment to Clause 40 defines appropriate authority to mean the Secretary of State in relation to England and the Welsh Ministers in relation to Wales.

Amendment 165, in clause 38, page 22, line 34, leave out "Secretary of State" and insert "appropriate authority".

This amendment has the effect of allowing the Welsh Ministers to make regulations under Clause 38(1) (power to make consequential and transitional provision etc). A linked amendment to Clause 40 defines appropriate authority to mean the Secretary of State in relation to England and the Welsh Ministers in relation to Wales.

Amendment 166, in clause 38, page 22, line 37, leave out "Secretary of State" and insert "appropriate authority".

This amendment is linked to an amendment that allows the Welsh Ministers to make amendments under Clause 38(1) (power to make consequential and transitional provision etc). A linked amendment to Clause 40 defines appropriate authority to mean the Secretary of State in relation to England and the Welsh Ministers in relation to Wales.

Amendment 167, in clause 39, page 23, line 9, at end insert

"or, where the regulations are to be made by the Welsh Ministers, the Senedd Cymru".

This amendment has the effect of making certain powers of the Welsh Ministers subject to the affirmative procedure before the Senedd Cymru. A linked amendment to Clause 40 defines appropriate authority to mean the Secretary of State in relation to England and the Welsh Ministers in relation to Wales.

Amendment 168, in clause 39, page 23, line 12, at end insert

"or, where the regulations are to be made by the Welsh Ministers, the Senedd Cymru".

This amendment has the effect of making certain powers of the Welsh Ministers subject to the negative procedure before the Senedd Cymru. A linked amendment to Clause 40 defines appropriate authority to mean the Secretary of State in relation to England and the Welsh Ministers in relation to Wales.

Amendment 169, in clause 40, page 23, line 23, at end insert—

"'appropriate authority' means—

(a) in relation to England, the Secretary of State;

(b) in relation to Wales, the Welsh Ministers."

This amendment to the interpretation provision in Clause 40 defines appropriate authority to mean the Secretary of State in relation to England and the Welsh Ministers in relation to Wales. A series of linked amendments change references to the Secretary of State to appropriate authority in order to allow the Welsh Ministers to make regulations in relation to Wales.

Amendment 170, in clause 42, page 24, line 21, leave out "Secretary of State" and insert "appropriate authority".

This amendment has the effect of allowing the Welsh Ministers to make regulations under Clause 42(2) (commencement). A linked amendment to Clause 40 defines appropriate authority to mean the Secretary of State in relation to England and the Welsh Ministers in relation to Wales.

Amendment 171, in clause 42, page 24, line 26, leave out "Secretary of State" and insert "appropriate authority".

This amendment has the effect of allowing the Welsh Ministers to make regulations under Clause 42(4) (commencement: transitional and saving provision). A linked amendment to Clause 40 defines appropriate authority to mean the Secretary of State in relation to England and the Welsh Ministers in relation to Wales.

Liz Saville Roberts: Diolch, Gadeirydd. As Professor Emyr Lewis of Aberystwyth University told this Committee in oral evidence, because this Bill is a private Member's Bill it has not gone through the usual process of engagement with devolved Governments. I recognise that there will be amendments and changes and amendments to amendments, but I can speak to the principle here and we will have to adapt as we move ahead, as we are learning to do in this Committee.

The Wales Act 2017 formally acknowledged the Sewel convention by amending section 107 of the Government of Wales Act 2006 with a declaration stating—this is important—that

"it is recognised that the Parliament of the United Kingdom will not normally legislate with regard to devolved matters without the consent of the Senedd."

It is in that spirit that work needs to be done to ensure that the devolved legislature in Wales and the complexities of legislating across reserved and devolved matters are fully considered and represented in the Bill. That is what these 28 amendments seek to do.

The use of the term "appropriate authority" does two things. First, in the here and now, it recognises the complexity of which competency lies where and with which Minister or Secretary of State. Secondly, it future-proofs the legislation, which we know is important. If and when there are any changes to devolved powers and competencies, the appropriate authority can move with time with the specifics of who is responsible for what.

Amendment 169 would amend clause 40 to include a definition of "appropriate authority", the term that is used in my other amendments. It would mean the Secretary of State in relation to England and the Welsh Ministers in relation to Wales, where those powers are devolved rather than reserved. The amendment would provide for my other amendments, which would modify each relevant mention of powers provided to the Secretary of State in the Bill, to supply Welsh Ministers with equivalent powers in Wales.

Amendment 144 would amend clause 5 to allow Welsh Ministers the same powers as the Secretary of State in England to specify the training, qualifications and experience of the medical practitioner representing the co-ordinating doctor, because that matter is devolved to Wales. Amendment 145, similarly, would require Welsh Ministers to consult persons they consider appropriate before making the relevant regulations in Wales.

Amendment 146 would amend clause 6 to allow Welsh Government Ministers equivalent powers to make provision around proof of identity. Amendment 147 would similarly amend clause 8 in relation to the training, qualifications and experience of the independent doctor; we are talking, of course, about the co-ordinating doctor.

And so on, and so on. I assume that hon. Members now understand the purpose of my various amendments. I am more than willing to explain them further if necessary, but otherwise I will skip ahead.

Amendments 155 and 156 would modify clause 30 so that the Welsh Government are provided with a power to issue a code of practice over arrangements in relation to this legislation in Wales. That might be a useful route into further discussions on the specifications of the codes of practice; it might also be significant in discussions with the hon. Member for Spen Valley and the Government about how to recognise legislative differences in safeguarding and the Welsh language.

Amendments 157 and 158 are also important. They would provide Welsh Ministers with the power to make regulations under clause 32 to ensure that assistance is available through the health service in Wales. That is the responsibility of Welsh Ministers. As Committee members know, Senedd Cymru voted against a motion to support an assisted dying law by 26 to 19, with nine abstaining. There are a number of issues of which we need to be aware when bringing an England and Wales law into Wales. To ignore them would be irresponsible; we do so at our peril, frankly, especially given that clauses 33 and 34 will place explicit obligations on Welsh Ministers and the chief medical officer for Wales.

I put it on the record that I am disappointed that the Committee was not able to question the chief medical officer for Wales. I understand that he was invited. As there are matters in the Bill that we do not deal with every day in this place, that would have been useful. The Bill is unprecedented, certainly for a private Member's Bill, in respect of the support, information and advice that the Committee needs, and that would have been an obvious opportunity for us to receive advice. I understand that the chief medical officer has advised on other pieces of legislation, including vaping, although that was Government legislation.

Kim Leadbeater: I can confirm that the chief medical officer for Wales was invited to give evidence. I do not know the circumstances of why he did not. If it is helpful for me or other colleagues to meet him, the offer is definitely open.

Liz Saville Roberts: I am grateful for the hon. Lady's intervention.

Amendments 161 to 165 relate to clauses 35, 37 and 38. Amendments 161 to 163 would provide for the Welsh Government to review the operation of the legislation in Wales, which is vital to understand the specifics of the Welsh context and to learn and adapt as appropriate. To not allow Welsh Ministers that power would be to dismiss the particularities of health policy in Wales, as well as the additional implications of contextual differences. I strongly believe that we require an impact assessment to understand those differences properly within the context of health being devolved to Wales, alongside significant population differences in relation to demographics, age and sickness.

10.45 am

To ensure that health policy levers are fully retained in Wales, alongside powers to adapt and tailor the operation of the Bill to the specific context, it is crucial to the successful implementation of any legislation in this area that it has the full consent and approval of Senedd Cymru. That is paramount. A legislative consent motion will be necessary, and it important that we have the discussions in this place before that moves forward. That is the basis of amendments 164 and 165, which would give Welsh Ministers the power to modify schedules 1 to 6 and make supplementary consequential or transitional provision. That is important as currently the forms introduced through the schedules will be monolingual. Members will be aware that I have been raising matters relating to the constitution and to Welsh language rights. To adhere to Welsh language regulations in Wales, the forms must also be available in Welsh. The forms that we sign off are very much an issue for this place.

Amending clause 40 through amendments 170 and 171 would give the Senedd and the Welsh Government the rightful authority to ensure that provisions are ready, adequate and enforceable in the Welsh context before their commencement in Wales—in other words, before the end of the two-year period. I tabled the amendments in an attempt to provide Senedd Cymru—the Welsh Parliament—and Welsh Ministers with their correct and rightful powers in areas that are devolved to Wales. We must be clear on that. That is what I have set out to do: that has always been my stated aim as a member of this Committee. I hope that Committee members will consider these practical amendments and support their inclusion in the Bill.

Danny Kruger: I will speak briefly in support of the amendments. The right hon. Member for Dwyfor Meirionnydd may want to intervene to request that the Minister respond to a couple of additional points.

It is very uncomfortable that the Bill ignores the devolution settlement in this way. It is regrettable that it was introduced in its current form in the knowledge that the Senedd in Wales rejected assisted dying a month earlier. That suggests either that originally little thought was given to including Wales in the Bill or that, subsequent to the vote in the Senedd, it was decided that the Bill would be imposed on Wales. It would be helpful to have clarification about the original intent.

I very much echo the points that the right hon. Lady made. She is absolutely right about the appropriateness of giving the Welsh Government powers to manage the Bill's operation and implementation if it passes. I would suggest a stronger process of implementation, reflecting the advice given by Professor Lewis, who gave evidence to us on Welsh law. In the light of the vote in the Senedd to reject assisted dying, he pointed out:

"The vote was against 'the principles of assisted dying', not only about how the NHS in Wales might be affected. It was a decision which the majority of the Senedd made about those *principles*, having reflected on the…issues raised."

Professor Lewis proposed a straightforward way of respecting that vote while recognising that, if this Bill passes, it will apply to Wales. He suggests that we should

"provide for different commencement provisions in the Bill. As things stand, under clause 42 of the Bill, most of the Bill will not come into force until the Secretary of State has brought it into force, with the approval of the UK Parliament. Why not provide that the Bill will only come into force in Wales when and if the Welsh Ministers bring it into force with the approval of the Senedd?"

The objection might be made that cross-border issues would be created if Wales does not proceed but England does. Nevertheless, that is a matter that devolution can cope with. It will have to cope with the cross-border issues that will arise if the Scottish Bill does not proceed, and of course we have cross-border issues between Wales and England with respect to organ donation, so I do not accept that the two countries need a uniform policy. I do not know whether the right hon. Lady or the Minister wish to comment on the suggestion that the Bill should commence in Wales only if Ministers bring it forward with the approval of the Senedd.

Liz Saville Roberts: The evidence for a commencement date would be associated with an impact assessment in Wales. That is why it is so important that Welsh Ministers have the power to get the information they need and to implement any changes that come forward.

Danny Kruger: I absolutely agree with the right hon. Lady. There is a whole set of challenges, including in England, in respect of the impact assessment and the Bill's commencement. Nevertheless, my suggestion is that we strengthen her proposal to empower Welsh Ministers to proceed. We should respect the devolution settlement and reflect what she describes as the "correct and rightful powers" of the Welsh Parliament to ultimately decide whether this law were to come into effect in Wales.

Stephen Kinnock: Amendments 144 to 171, tabled by the right hon. Member for Dwyfor Meirionnydd, relate to the powers and duties vested in the Secretary of State under the Bill. The purpose of the amendments is to change all references throughout the Bill from "Secretary of State" to "appropriate authority". Amendment 169 defines "appropriate authority" as the Secretary of State in relation to England and as Welsh Ministers in relation to Wales. I note the intent of the promoter of the Bill, my hon. Friend the Member for Spen Valley, that the Bill's provisions extend and apply to both England and Wales.

The amendments would mean that all the powers and duties vested in the Secretary of State are instead shared between the Secretary of State where they relate to England and Welsh Ministers where they relate to Wales. I would like to put on the record the Government's continued commitment to devolution and to working with the devolved Governments. Having taken a neutral position on the Bill and the matter of assisted dying, the Government are still committed to working with the Welsh Government to resolve legal and technical issues and discuss constitutional matters that might arise thoughtfully and amicably.

With regard to the phrase "appropriate authority", the challenge is that in each case throughout the Bill the appropriate authority would be determined by the devolution position of the clause in question—what is the underlying question that the clause seeks to address, and is that a reserved or devolved matter? I have discussed this with parliamentary counsel and others, and the concern is that a blanket provision of this nature may well be premature at this stage. Until we have finalised and determined the constitutional nature and impact of each clause, putting a blanket provision in place may run counter to that process.

Liz Saville Roberts: I have a simple question: in relation to the Sewel convention, if not now, when? We should have clarity on these points. I hope the Minister will forgive me if this is slightly longer than an intervention, but he gives me no option in the here and now but to withdraw the amendments, because I will not push them to a vote if it is likely to be lost. However, these are serious questions. How does this respect the Sewel convention? As a Back-Bench MP, I am not in a position to answer that, and I would have expected the Government to provide clarity on these points earlier than Committee stage. I assure the Minister that I will push this issue on Report if we do not have a satisfactory resolution on the Sewel convention.

Stephen Kinnock: It is, of course, the right hon. Lady's prerogative to press amendments as and when she sees fit. I am simply flagging that terminology such as "appropriate authority" risks tying the hands of the legislative process in a way that could have perverse outcomes. A clause that should be the lead responsibility of Welsh Ministers could instead end up in the hands of Secretary of State due to the lack of clarity or relative vagueness of the term "appropriate authority".

The Government's suggestion is to work through each clause and be specific about the lead responsibility in each case—is it the Secretary of State or Welsh Ministers? We are open to discussing whether it is better to do it that way or with the terminology "appropriate authority"; we are simply flagging that there are risks associated with that term.

Liz Saville Roberts: Before the Minister sits down, will he commit to engaging with me on this issue to identify the specific needs in the spirit of what I have bought forward?

Stephen Kinnock: Yes, absolutely, and before Report. Let us ensure that we do that, and that parliamentary counsel is in the room. I am not a constitutional lawyer, so we definitely need people in the room who can speak to these issues. Of course, it also needs to be done in close dialogue with colleagues in the Welsh Government, particularly given what was said earlier about the need for a legislative consent motion.

The Chair: For clarity, amendments negatived in Committee, if they are pressed today, can be tabled again on Report. I say that in case the right hon. Lady wished to press the amendment and it was defeated. I hope there was clarity from me on that.

Kim Leadbeater: I welcome this important debate about the impact of this potential legislation on Wales. I thank the right hon. Member for Dwyfor Meirionnydd for her valuable contributions. I also welcome the Minister's commitment to meet the right hon. Lady and me for discussions with parliamentary counsel and the relevant authorities.

This is really important. The criminal justice system covers England and Wales, so it is important for the Bill to do the same, given that it disapplies the Suicide Act in certain very carefully defined circumstances. But health is, of course, devolved and the Welsh Government quite rightly make decisions on the Welsh NHS. I want to make it clear that I recognise that reality and its importance, and I am fully committed to observing the same conventions that the Government would if this were a Government Bill.

As has been said, I am working with UK Government officials to ensure that the right steps are taken at the right time, and I would expect to engage colleagues in the Welsh Government as the Bill progresses. Indeed, I really look forward to doing so and would be happy to visit the Senate if appropriate—although, as Members can tell, I need to work on my Welsh a bit. I look forward to continuing these conversations.

Liz Saville Roberts: I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Amendment proposed: 359, in clause 5, page 3, line 18, at end insert—

"(ba) who has conducted the preliminary discussion in accordance with section 4,"—*(Danny Kruger.)*

This amendment requires that the coordinating doctor has conducted a preliminary discussion prior to witnessing the signing of the first declaration.

Question put, That the amendment be made.

The Committee divided: Ayes 3, Noes 19.

Division No. 33]

AYES

Kruger, Danny	Paul, Rebecca
Olney, Sarah	

NOES

Abbott, Jack	Malthouse, rh Kit
Atkinson, Lewis	Opher, Dr Simon
Campbell, Juliet	Richards, Jake
Charalambous, Bambos	Sackman, Sarah
Francis, Daniel	Saville Roberts, rh Liz
Green, Sarah	Shah, Naz
Hopkins, Rachel	Shastri-Hurst, Dr Neil
Joseph, Sojan	Tidball, Dr Marie
Kinnock, Stephen	Woodcock, Sean
Leadbeater, Kim	

Question accordingly negatived.

11 am

Danny Kruger: I beg to move amendment 360, in clause 5, page 3, line 23, at end insert—

"(e) who, If receiving remuneration for the provision of services in connection with the provision of assistance to that person in accordance with this Act, makes publicly available an annual statement setting out total turnover from the provision of services under this Act and the number of patients assisted, and such other information as the Secretary of State may specify by regulations."

This provides that if the coordinating doctor receives remuneration for providing assisted dying, they must then make a public annual statement about their operation.

The Chair: With this it will be convenient to discuss amendment 361, in clause 5, page 3, line 28, at end insert—

"(7) Regulations under subsection (3)(e) are subject to the affirmative procedure."

This is linked to Amendment 360.

Danny Kruger: The amendment speaks to the general confusion we remain in about how the assisted dying law would be implemented and who would operate it. We are in a great cloud of unknowing about whether we are talking about an NHS service or a private service. If there were to be a private service and people were to be paid to deliver it outside the NHS, the amendment would clarify obligations regarding how their remuneration would be recorded.

There is an established precedent for publishing financial interests where there is a potential for a conflict of interest. Senior officials in NHS England, NHS trusts and the Medicines and Healthcare products Regulatory Agency must declare financial interests—including relationships with pharmaceutical companies—in public registers. Those interests include consultancy fees, gifts, hospitality, shareholdings in pharmaceutical companies or research funding, because there is a concern that those influence drug approvals, procurement and healthcare policy and that there is a risk of bias.

NHS England guidance on managing conflicts of interest encourages the detailed disclosure of significant payments from pharmaceutical companies, often with exact figures or ranges for payments above a £500 threshold. The Association of the British Pharmaceutical Industry runs Disclosure UK, which requires pharmaceutical companies to publicly report payments to healthcare professionals and organisations. It would be appropriate to follow this well-established precedent and ensure that people involved in the administration of assisted dying are accountable for the transparency for their remuneration.

Clause 5(3) recognises that there could be a conflict of interest and that there is a risk that someone who is related or might benefit financially may not be a neutral assessor of someone who wishes to die, but clause 40(4), which comes rather late in the Bill—it should be up front—specifies that

"a registered medical practitioner is not to be regarded as benefiting financially or in any other material way from the death of a person by reason only of the practitioner receiving reasonable remuneration for the provision of services".

Here is where we discover that the Bill does envisage remuneration, but people being remunerated are excluded from the definition of people who financially benefit from the service. To me, that feels dangerous.

Although it has not resolved the question of whether assisted dying is to be an NHS service, the Bill clearly envisages the establishment of a private market for these services, perhaps with a specialist service like Dignitas. Are we content with the Bill's assertion that remuneration is not a matter for scrutiny? What level of remuneration would we consider reasonable? What level would we consider excessive—remuneration that is capable of influencing a doctor's thinking? Would they be paid for administering assisted death on a per patient basis, or as a cumulative practice?

As MPs, should we not have some unease at the idea that this could be a highly profitable specialism for private practice? Transparency on what is being charged and who is profiting from the service would help us to understand what is happening in the system that is being established. I suggest that we bring more sunlight into the system, as we do in many other areas.

It is notable that there is little public data on what is charged, or how much revenue assisted dying generates for medical practices, in other countries where assisted dying is a private service. That is regrettable, and I hope we will not replicate that here. We do know that at Dignitas, which is a not-for-profit, the cost for a single patient is between £5,000 and £8,500 in fees alone. What is reasonable remuneration for a practice that provides assisted dying here in the UK? The term is entirely undefined, and I would be grateful for any clarity.

Kim Leadbeater: I understand the hon. Gentleman's keenness to get to the debate on clause 32, on the provision of the service—we will come to that in due course—but this conversation is about the amendment. To be clear, there is no expectation that assisted dying would be set up as a private enterprise or service. It would be delivered within the provision of the NHS.

Danny Kruger: I am glad to have that suggestion. Clause 32 is extremely broad. It basically empowers the Secretary of State to set up a service in any way they choose, potentially including in the private sector. The hon. Lady says it is not envisaged that would happen, as she is suggesting this should be an NHS service. I am grateful for the clarity, but I wish it were clearer in the Bill.

Kim Leadbeater: It will be.

Danny Kruger: I am glad to hear we will have more clarity. Having assisted suicide as an NHS service is fraught with enormous risks, along the lines we have discussed and will no doubt continue to discuss. At least we have that clarity. If the hon. Lady is going to rule out private provision and profit making or remuneration of people outside the NHS, I would be grateful for amendments specifying that. That would help to address this question.

My amendments would mean that if there is private provision of assisted suicide, as the Bill currently allows, the public and Parliament could understand who is being paid what, which I think is very appropriate.

Jack Abbott: To give the Committee a sense of clarity, is the hon. Gentleman saying he wants the finances to be in the public domain, so that if provision were to go down a private route, everyone would know what an individual is charging for these services? Or is he suggesting a cap on services? What is the intention of his amendments?

Danny Kruger: My amendments state that if a medical professional is paid for delivering assisted suicide, the money they receive should be transparent. The answer is therefore the former.

I do not propose any cap. If we end up with a private service, although the hon. Member for Spen Valley has just told us that we will not, it might be appropriate to create a scale of charges. My suggestion is that we need absolute clarity. I also think we should use the affirmative procedure to approve the regulations on the transparency of finances. This should be something that Parliament expressly approves.

Kit Malthouse (North West Hampshire) (Con): My interpretation of what the hon. Member for Spen Valley said is that, as long as the service is available on the NHS, it is up to me whether I go private. In such circumstances, I could have it on the NHS if I really wanted. If I chose to go private, as I might if I were having a baby at the Portland hospital or cosmetic surgery at King Edward VII's hospital in Marylebone, why would my hon. Friend the Member for East Wiltshire want to know the private arrangement between me and my physician?

Danny Kruger: I am grateful for that clarity, although we now seem to be less clear than we were. I understood the hon. Member for Spen Valley to be saying that there will not be private provision, but my right hon. Friend is saying that there may be.

Kim Leadbeater: Will the hon. Gentleman give way?

Danny Kruger: It would be helpful if the hon. Lady clarified whether private provision will be allowed under the Bill, because I think we have a party split. My right hon. Friend the Member for North West Hampshire supports private provision, but the hon. Lady suggests this should be done only on the NHS.

Kim Leadbeater: This service, like many others, will be delivered through a range of providers, as alluded to by the right hon. Member for North West Hampshire. I understand the keenness to have this debate now, but we will come on to it further down the line. The hon. Member for East Wiltshire is right that this is really important.

Danny Kruger: It certainly is. Okay, so it could be either. This will be an NHS service, with all the implications for general practice, doctor-patient relations and secondary care and social care, but there will also be an opportunity to deliver it privately, without any clarity or transparency on who is being paid and how.

In answer to my right hon. Friend the Member for North West Hampshire, this is different from cosmetic surgery, as even cosmetic surgery is regulated. In many ways, there is more regulation of the administering of Botox than there is in this Bill. The administering of assisted dying is of a significantly different category and gravity. It is appropriate and important that financial interests are clearly revealed and made public, particularly with the new intervention we are creating. If other hon. Members do not support the amendment, what provisions

do they propose that would reveal where there may be potential conflicts of interest and how we may regulate this?

Dr Simon Opher (Stroud) (Lab): I thank the hon. Member for East Wiltshire for the amendment. The set-up of this scheme is similar to other NHS services. Essentially, a medical professional will opt in to provide the service. That will involve extensive training followed by a short exam, as it does in Australia and California, after which they will be accredited under the scheme—that is how I understand it will happen in the UK. No one is forced to provide the service, but training is offered and many doctors take that up. Therefore, it is a medically based service.

The British Medical Association will then negotiate the fee for doing the assessment with the Department of Health and Social Care. That is not about agreeing to provide the service; it is about doing the assessment. That is mirrored in many aspects of general practice, which itself is a private service contracted to the NHS. It is very complicated. It would be inaccurate to portray this as a private service, where people may profiteer, as it is based on medical professionals performing a duty for which they are trained and for which the price is clear to the general public, because it is negotiated and published.

On publishing the number of patients seen by a single doctor and the fees that doctor has accrued from the scheme, that is not something that happens for things like minor operations, which we perform outside general medical services, although we are rewarded by the Government at a set fee. There are other such services—inserting a coil, for example—where we are given a certain amount of money.

How this is arranged is very complicated. Doing appraisals, being a trainer and all these things have a price attached, and we need training before we can perform the service. I see this scheme as no different. The problem with publishing how many patients have been seen by a single doctor regarding assisted dying is that it puts a target on that doctor. As we have seen with abortion clinics and even this Committee—certain Committee members have been targeted by the press for what they have said—this is a very sensitive issue, and it would not be fair to publish the figures so that doctors could be targeted in the press and made to feel unworthy in all those ways. It is extremely difficult.

Dr Neil Shastri-Hurst (Solihull West and Shirley) (Con): The hon. Gentleman makes a powerful argument about doctors being vilified in the press, but does he believe there is a risk that it may go further and present a genuine safety risk to those doctors?

Dr Opher: Exactly. That is what worries me. I acknowledge what the hon. Member for East Wiltshire said about pharmaceutical sponsorship, but I do not think that has anything to do with what we are talking about here. What we are talking about is specifying what doctors are doing as part of their daily job, for which they are trained. It would not be fair to publish those figures and put those doctors at risk.

Naz Shah: I appreciate what my hon. Friend is saying, because I have mixed views on this. I would like to understand what would be appropriate. My concern is that there will be a difference, because doctors normally have these set-ups for treatment options but, in this instance, the service is not a treatment, so to speak. I genuinely want to understand: in his eyes, what would a good service that provided scrutiny and accountability look like?

Dr Opher: There are examples. Appraising other doctors, for instance, is specified as a job that doctors are trained for, and it is paid at a set rate agreed with the Department of Health and Social Care. There are many instances where this occurs. I totally agree that the fee a doctor attracts for the service should be clearly specified and in the public domain, but I do not agree that a single doctor should be identified as having seen, say, 10 patients who have requested assisted death. I think that is unnecessary, will not lead to increased patient safety and will make it less safe for the medical practitioners too.

11.15 am

Stephen Kinnock: Amendments 360 and 361 introduce requirements on the co-ordinating doctor. Amendment 360 would insert an additional condition into the definition of a co-ordinating doctor and would require a co-ordinating doctor who receives financial payment for providing assisted dying to make an annual statement declaring publicly their total turnover from providing the service, the number of people they have assisted and any other information specified in regulations.

The related amendment 361 would require that any regulations specifying the information to be made available must be subject to the affirmative procedure. It is not clear whether the amendments are intended to apply to both private and NHS providers. It could create difficulty if the requirement were to apply to NHS providers, as a doctor is unlikely to know the total turnover from providing an assisted dying service.

As the Bill's promoter, my hon. Friend the Member for Spen Valley has said that her intent is to ensure that the assisted dying service is available as an integral part of the NHS. Officials are working on amendments to later clauses to establish the operating model for her consideration.

Rebecca Paul (Reigate) (Con): Does the Minister not think the word "remuneration" refers to the amount of income received specifically by the doctor, rather than by any organisation or company?

Stephen Kinnock: As my hon. Friend the Member for Stroud has just said, the picture is very complex because there are tariffs for services. Doctors receive a tariff for each service across the entire panoply of everything they do, particularly general practitioners who provide a very wide range of services. They are remunerated on the basis of a tariff that is negotiated in the GP contract between the Department of Health and Social Care and, primarily, the BMA. When a doctor operates in that environment, it is difficult to pick out their turnover from a particular service.

As my hon. Friend the Member for Stroud said, picking out an individual doctor and saying how much money they have made from a particular service, whether assisted dying or any other service, would put a particular focus on that doctor. We are drawing a distinction here

with what the tariff could and should be, which we will need to discuss alongside the operating model in later clauses. Moving from being transparent on the tariff to saying, "That doctor over there made this much money from providing this service," is a whole new ball game.

Danny Kruger: I am grateful to the Minister for raising a number of points, including the extraordinary revelation that we are about to find out how the Bill will operate in practice, with amendments yet to be developed even though we have been debating the Bill for a couple of weeks.

The difference between the tariff and a doctor's income is fine, but if the tariff is to be clearly specified—no doubt it will be—how could it be complicated to determine how many tariffs a particular practice has received? I recognise that there is a separate question about whether it is appropriate to reveal that, but why is it difficult to identify how many individual tariffs a particular practice has received?

The Minister has described the tariff income, but my other concern is about the sponsorship, gifts, hospitality and fees of all sorts that the pharmaceutical companies are always trying to administer. Will he address the question of whether that should be transparent as well?

Stephen Kinnock: The challenge in the hon. Gentleman's amendment is the term "total turnover." A GP would have to extrapolate from the service provided to a whole range of other costs that may apply—for example, the share of the overhead they pay into their primary care network, the share of admin costs or the rent on their building. The definition of total turnover is the entire cost and entire revenue from the tariffs. As officials have made clear, this additional level of complexity would be an onerous task, although not necessarily impossible.

Total turnover is one side of this issue; the other, much more salient point is the quantum leap between having transparency on a particular tariff and pointing at a specific doctor and saying, "You over there—you did this much work on that much tariff, and that's how much money you made for it." There is a big difference between the two.

Naz Shah: I also do not like the idea of doctors being identified in such a way, as they have with abortion clinics, but I am trying to understand how we will protect these services. If it is an NHS provision and specialty, with doctors in certain practices signing up to provide services for assisted dying and becoming either the primary or the secondary doctor, by definition those will be the practices to which people will refer. That will become common knowledge, just as it is for musculoskeletal or podiatry services, for example. In this instance, there would be an assisted death service, and there would clearly be practices that do not provide it. How would we then protect the doctors? How will the Government respond to all these concerns?

Stephen Kinnock: If we are specifically talking about the amendments tabled by the hon. Member for East Wiltshire, he is saying that the total turnover from providing this service should be publicly available—it should be published—so I assume he thinks it should be on a website that everybody can see.

My hon. Friend the Member for Bradford West is asking about the knowledge that, if someone wishes to seek an assisted death, they can go to a particular practitioner or service. That is baked into the Bill, and clearly those doctors who wish to opt into the service will be doing so with their eyes open—they will know that they are providing that service. We must ensure that doctors feel protected if there is a sense of risk.

It would of course be deeply regrettable if there were to be threats or risks to doctors, but the evidence from other countries suggests this has not led to some of the deeply unfortunate things we have seen around abortion clinics, for example. It does not seem to have led to that, but of course we as a Government always need to be vigilant in monitoring all our services to ensure that our excellent medical professionals are getting the support they need.

Rebecca Paul: I thank the Minister for that useful explanation. Does he agree that the setting of the tariff will be key, because it could either incentivise or disincentivise the provision of the service?

Stephen Kinnock: I agree. Like any other aspect of what doctors and general practitioners do, this service is based on remuneration. They are professionals and should be remunerated as such, so the tariff will be important. It is also important that we do not jump ahead into defining the operating model. As I said, officials are working on this with the Bill's promoter, and it will be made clear when we get to the relevant clauses.

Kim Leadbeater: Hopefully the Minister and other colleagues are reassured that, if the Committee agrees to the introduction of the voluntary assisted dying commission, monitoring will be very intense and reporting will be very robust. That might allay some of the fears that have been raised today.

Stephen Kinnock: As I have repeatedly said, the Government are neutral on the fundamental question of the Bill, but we are absolutely committed to ensuring it is workable should it receive Royal Assent. The role of the commission will be pivotal in ensuring that the Bill is workable and that all the necessary monitoring and regulation mechanisms are in place.

11.25 am

The Chair adjourned the Committee without Question put (Standing Order No. 88).

Adjourned till this day at Two o'clock.