

PARLIAMENTARY DEBATES

HOUSE OF COMMONS
OFFICIAL REPORT
GENERAL COMMITTEES

Public Bill Committee

TERMINALLY ILL ADULTS (END OF LIFE) BILL

Twenty First Sitting

Tuesday 11 March 2025

(Afternoon)

CONTENTS

CLAUSES 9 TO 11 agreed to, with amendments.

CLAUSE 12 under consideration when the Committee adjourned till
Wednesday 12 March at twenty-five minutes past Nine o'clock.

Written evidence reported to the House.

No proofs can be supplied. Corrections that Members suggest for the final version of the report should be clearly marked in a copy of the report—not telephoned—and must be received in the Editor’s Room, House of Commons,

not later than

Saturday 15 March 2025

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The Committee consisted of the following Members:

Chairs: PETER DOWD, CLIVE EFFORD, SIR ROGER GALE, † CAROLYN HARRIS, † ESTHER McVEY

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

Public Bill Committee

Tuesday 11 March 2025

(Afternoon)

[ESTHER McVEY in the Chair]

Terminally Ill Adults (End of Life) Bill

2 pm

The Chair: I remind the Committee that electronic devices should be turned off or switched to silent mode and that tea and coffee are not allowed in the Committee Room.

We will now continue line-by-line consideration of the Bill. I remind Members that interventions should be interventions, by which I mean that they should be short and should raise a point of clarification or ask a question; they are not speeches. Members who wish to give a speech should bob, and should continue to do so at the appropriate points in the debate in which they wish to take part. When Members say “you”, they are referring to the Chair, which is me. If they do not mean me, they might find it easier to look at me and direct their speeches to me, so that they address the Committee correctly.

Clause 9

DOCTORS’ ASSESSMENTS: FURTHER PROVISION

Question proposed (this day): 201, in clause 9, page 5, line 36, leave out “and their medical records” and insert “, examine such of their medical records as appear to the assessing doctor to be relevant.”.—(Kim Leadbeater.)

This amendment provides that the duty on an assessing doctor to examine a person’s medical records is limited to records appearing to the doctor to be relevant.

Question again proposed, That the amendment be made.

The Chair: I remind the Committee that with this we are discussing the following:

Amendment 422, in clause 9, page 5, line 36, after “records” insert

“make such enquiries of professionals who are providing or have recently provided health or social care to the person as the assessing doctor considers appropriate.”

This amendment requires an assessing doctor to make such enquiries of professionals who are providing, or have recently provided, health or social care to the person as the assessing doctor considers appropriate.

Amendment 468, in clause 9, page 5, line 37, at end insert—

“(aa) ask the person why they are seeking an assisted death.”.

Amendment 423, in clause 9, page 6, line 20, at end insert—

“(2A) To inform their assessment, the assessing doctor must—

- (a) consider whether they should consult a health professional or social care professional with qualifications in, or experience of, a matter relevant to the person being assessed;

- (b) consult such a professional if they consider that there is a need to do so.

(2B) Where an assessing doctor consults a professional under subsection (2A)(b), the assessing doctor must give a written record of the consultation to the other assessing doctor.”.

This amendment requires the assessing doctor to consider whether they should consult specialist health or social care professionals, and to consult them if they consider there is a need to do so. A record of any consultation must be shared with the other assessing doctor.

The Minister for Care (Stephen Kinnock): It is a pleasure to serve under your chairship this afternoon, Ms McVey. When we adjourned at 11.25 this morning, I had just been discussing amendment 201, but I will start again.

Amendment 201 seeks to clarify the wording in clause 9 relating to doctors’ assessments. It provides that the duty on an assessing doctor to examine a person’s medical records applies only to records that appear relevant to the doctor. The effect of the amendment is to make it clear as part of the assessment process that the assessing doctor is required only to review medical records that are considered by the doctor to be relevant to the person’s request to seek an assisted death.

Amendment 422 would add an additional requirement on an assessing doctor to make inquiries of professionals who are providing or have recently provided health or social care to the person and make such other inquiries as the assessing doctor considers appropriate. This applies to the co-ordinating doctor carrying out the first assessment and the independent doctor carrying out the second assessment.

Amendment 423 would require the assessing doctor to consider whether they should consult specialist health or social care professionals. These professionals should have qualifications in or experience of a matter relevant to the person being assessed, and they must be consulted if the assessing doctor considers that there is a need. This applies to the co-ordinating doctor carrying out the first assessment and to the independent doctor carrying out the second assessment. The amendment also provides that a record of any consultation with the specialist health or social care professionals must be shared with the other assessing doctor.

As the Bill is currently drafted, the co-ordinating doctor and the independent doctor are required to ascertain that the person has

“a clear, settled and informed wish to end their own life”.

That is set out in clauses 7 and 8. There is also a power in clause 30(1)(a) for the Secretary of State to issue codes of practice in connection with

“the assessment of whether a person has a clear and settled intention to end their own life”.

There are requirements for the assessing doctors to ascertain that a person is making the declaration

“voluntarily and has not been coerced or pressured by any other person”.

That is set out in clauses 7(2)(g) and 8(2)(e). Amendment 468 would supplement those requirements with a requirement for the assessing doctor to ask a person why they are seeking an assisted death. I hope that those observations have been helpful to the Committee.

Kim Leadbeater (Spenn Valley) (Lab): I have nothing further to add.

Question put, That the amendment be made.

The Committee divided: Ayes 19, Noes 2.

Division No. 42]

AYES

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

NOES

Joseph, Sojan	Kruger, Danny
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Question accordingly agreed to.

Amendment 201 agreed to.

Amendment made: 422, in clause 9, page 5, line 36, after “records” insert

“make such enquiries of professionals who are providing or have recently provided health or social care to the person as the assessing doctor considers appropriate.”—(*Kim Leadbeater.*)

This amendment requires an assessing doctor to make such enquiries of professionals who are providing, or have recently provided, health or social care to the person as the assessing doctor considers appropriate.

Amendment proposed: 468, in clause 9, page 5, line 37, at end insert—

“(aa) ask the person why they are seeking an assisted death.”—(*Rebecca Paul.*)

Question put, That the amendment be made.

The Committee divided: Ayes 7, Noes 15.

Division No. 43]

AYES

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

NOES

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

Question accordingly negated.

Dr Neil Shastri-Hurst (Solihull West and Shirley) (Con): I beg to move amendment 93, in clause 9, page 6, line 1, leave out “might” and insert “is to”.

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

Amendment 305, in clause 9, page 6, line 3, after “about death” insert

“and any other effects in addition to death.”

This amendment would require the assessing doctor to explain effects the provided substance would have in addition to death.

Amendment 142, in clause 9, page 6, line 3, after “death” insert

“and how it will be administered”.

This amendment requires the assessing doctor to explain and discuss with the person how the substance that might be provided to assist the person to end their own life will be administered.

Amendment 362, in clause 9, page 6, line 3, after “death” insert

“and the risk and nature of possible complications including pain”.

This requires the doctor to explain the risk of possible complications to the person.

Amendment 306, in clause 9, page 6, line 6, after “section 18” insert

“including the escalation of medical intervention”.

This would require the assessing doctor to include the escalation of medical intervention in their discussion of the person's wishing in the event of complications arising in the administration of the substance under section 18.

Dr Shastri-Hurst: It is a pleasure to serve under your chairmanship, Ms McVey, and to speak to this group of amendments. Amendments 93, 305, 142 and 362 relate to clause 9(2)(b)(iv); amendment 306, tabled by the hon. Member for York Central (Rachael Maskell), relates to clause 9(2)(c).

Clause 9(2)(b)(iv) stipulates:

“The assessing doctor must...explain to and discuss with the person being assessed...the nature of the substance that might be provided to assist the person to end their own life (including how it will bring about death)”.

My amendment 93 would replace “might” with “is to”. In my view, the word “might” creates an air of possibility. The Oxford English Dictionary gives the following definition:

“A possibility as distinct from a certainty”.

The Cambridge Dictionary goes somewhat further, defining “might” as the expression of a

“possibility that something will happen or be done, or that something is true although not very likely”.

In the context of the Bill, I consider that the use of “might” would create too ill-defined a concept.

For a patient to provide informed consent, it is necessary that the healthcare professional set out the relevant information in sufficient detail to enable that person to make an educated decision. In the circumstances of providing a substance, it follows that that information must include what that substance is. In my submission, it is insufficient simply to inform a patient that they might be provided with a substance, although they are just as likely, if not more likely, to receive another substance. Changing “might” to “is to” would provide greater certainty and precision in the wording of the Bill.

I recognise the concerns that have been raised that adopting amendment 93 would overly restrict which substance can be used, which may create an issue if the substance needs to be changed, for example if it was to be taken orally but has to be administered via a different route because the individual is no longer able to ingest orally. To my mind, however, the amendment would not prohibit a clinician from setting out to the individual a range of substances that could be used to provide them with the ability to end their own life, as long as the clinician includes the substance that is used and, crucially,

[*Dr Shastri-Hurst*]

the person seeking an assisted death indicates that in those circumstances they are content for that particular substance to be used. For example, it would be entirely open to an individual to inform a clinician that they are happy with regimes A, B and C, but not D.

Danny Kruger (East Wiltshire) (Con): I absolutely agree with what my hon. Friend is trying to do. This is a genuine question: does he think that it is possible at this stage for the Government, the Medicines and Healthcare products Regulatory Agency, the NHS or whoever to provide the information that would be required? What is needed to enable the Bill to come into effect with the amendment that he proposes, so doctors are able to say exactly what drugs will be used?

Dr Shastri-Hurst: In the scenario that I envisage, as we have seen in other jurisdictions, there are a variety of regimes that could be used in the given circumstances. It would be appropriate for an approved list of medications and substances to be a delegated matter for the Secretary of State. As medical and pharmacological studies progress, there may be changes to those regimes, so I do not propose putting a list on the face of the Bill. The way I envisage it operating, if the Bill comes into law, is that there would be an approved list of substances that would be open to use. There would have to be a range; we are acutely aware that there are supply chain issues at times, so limiting it to just one regime would be impracticable. I believe that amendment 93 would strengthen the wording of the Bill to provide greater certainty that the nature of the substance to be provided will be explained to and discussed with the person who is seeking an assisted death. I am grateful to my hon. Friend for indicating his broad support for the amendment.

I turn to amendment 305, tabled by the hon. Member for York Central. I appreciate the premise of the amendment, but I have some concerns about the precision of the drafting. It would require the assessing doctor to explain the effects of the provided substance, in addition to how it would bring about death. In its current form, the Bill requires the discussion with the assessing doctor to set out how the provided substance will result in death. My understanding is that the intent of amendment 305 is that they set out the side effects beyond those directly related to the mechanics of bringing about death; this would include any wider discussion around side effects.

2.15 pm

It is important to consider the specific meaning of “side effect”: an effect of a drug, chemical or other medicine that is in addition to its intended consequences. My understanding is that specifically using the term “side effect” in amendment 305 would make the drafting more precise and would achieve the effect that the hon. Member for York Central intends.

In many ways, however, I feel that the amendment is unnecessary, because a discussion of side effects should be incorporated into any informed consent discussion. Additionally, subsections (2)(b)(iv) and (2)(c) of clause 9 indicate, in conjunction, that there will be a discussion of any complications that may arise as a result of substances given. It flows from that, I submit, that there must be a conversation about side effects.

Sojan Joseph (Ashford) (Lab): Currently, when we start a patient on any medication, we usually give out information on indications and contraindications. If patients ask for one, we will give them a leaflet with information about the medication. Can the hon. Member clarify whether the amendment would help in that situation? Does he agree that a leaflet should be given to the patient?

Dr Shastri-Hurst: The hon. Member makes an important point. In practice, one would of course discuss the side-effect profile of any medication or substance to be administered. I do not feel that specifying that in the Bill, as amendment 305 is drafted, would achieve its purpose. The amendment refers to “any other effects”, but it does not specifically mention side effects. In any event, it must flow from the interaction between clause 9(2)(b)(iv) and clause 9(2)(c) that the conversation about complications as a result of the administration of a substance will encompass a conversation about side effects.

It is worth noting that all substances have a side-effect profile; what the side effects are will be specific to the substance in question. I do not think it a helpful improvement to the Bill to presuppose what the side effects may be. Amendment 305, although imperfect, is therefore preferable in my view to amendment 362, which would require that specific side effects be set out and which presupposes a scenario involving a particular set of medication.

Nevertheless, I remain concerned about the wording of amendment 305. I would be grateful if the hon. Member for Spen Valley provided some reassurances as to the steps she has taken to honour the intention of the amendment tabled by the hon. Member for York Central and achieve a tighter piece of legislative drafting.

I turn to amendment 142, tabled by the hon. Member for Broxtowe. It seeks to ensure that the discussion with the assessing doctor includes a discussion of how the substance will be administered. Although it may not be strictly necessary, because that should be a conversation that takes place when someone is going through an informed consent process, I do not consider that its inclusion would undermine the operability of the Bill. I am therefore minded to support the amendment. I do not consider that it will be restrictive should the circumstances change, because there may be a broad conversation about the variety of substances that can be administered, depending on the circumstances. As the drafting of the Bill does not preclude or prohibit such a wider discussion, it would be eminently sensible to include the route of administration.

Amendment 306, in the name of the hon. Member for York Central, would require the assessing doctor to include the escalation of medical intervention in their discussion should complications arise. In many ways, that issue is covered by clause 9(2)(c), so the amendment would not aid the operability or interpretation of the Bill. It would be much better dealt with under the code of conduct, to avoid the Bill becoming overly prescriptive and to allow flexibility as scientific and medical knowledge adjusts and adapts over time.

Juliet Campbell (Broxtowe) (Lab): I will speak to amendment 142, which would insert “and how it will be administered”

into the Bill. It would require the assessing doctor to explain and discuss with the person how the substance that might be provided to assist them to end their life will be administered.

The amendment would be a key step towards giving peace of mind to a terminally ill individual who is seeking an assisted death. It would also preserve their autonomy right up to the final stage. Ensuring that the method of administration is thoroughly explained would provide the doctors and the individual seeking an assisted death with the opportunity to consider the options—if there are options available to them—and decide which method would best preserve the autonomy of that individual.

Assisted dying presents many opportunities for individuals to be coerced, especially at the final stage—death itself. Therefore, the method of administration is key information for the individual to know, and it is not sufficient for it to be withheld from them. We must make it a prerequisite of the Bill that it is supplied. Making an informed choice about the assisted death pathway involves careful consideration, and knowing and understanding every step of the process. It is appropriate for the person to maintain their agency. Minimising the role played by the doctor at the administration stage is also key to ensure that the final act belongs to that individual.

We must acknowledge that many individuals seeking assisted death may experience significant mobility and physical limitations, particularly because of their terminal illness. Those limitations can affect their ability to engage with the process in ways other people may take for granted. For example, a patient suffering from severe weakness, paralysis or chronic pain might have difficulty physically positioning themselves or administering some types of substance, depending on the options available. A person may have difficulty swallowing and would not be able to ingest a substance in the form of a pill, but they may be able to autonomously operate a system that would allow them intravenous administration.

In these cases, the method of administration must be carefully considered and explained in a way that accommodates the patient's unique physical needs. By discussing the challenges openly at this stage, doctors can help to ensure that the patient understands the options open to them, while making the process as comfortable and accessible as possible. Addressing their mobility and physical limitations in this context is not only a matter of practicality, but a reflection of our compassion and respect for that individual's circumstances.

By limiting the doctor's physical role, we also ensure that the patient retains control over the process. Making the act of self-administration as independent as possible ensures that the final part of the process gives the patient agency in choosing how and when to end their life. The individual must maintain a primary role in their death, but the actual administration is the final assurance and assertion of the individual's choice to end their life. The amendment emphasises the importance of ensuring that, within the Bill, the doctor's involvement is limited to preparation and support. That is key to making sure that the patient's final moments are self-directed and as free from any unnecessary external interventions as possible.

Subsection 6 of clause 18, on the provision of assistance, discusses the role of the doctor in administration. It says that a doctor might

“assist that person to ingest or otherwise self-administer the substance.”

By ensuring that the method of administration of the substance aligns with the physical capabilities that a person has to self-ingest, which may be limited, we limit the role played by the doctor at this crucial stage, and limit the chance of the coercion of the individual or of the individual having a death that lacks real autonomy.

In conclusion, amendment 142 plays a crucial role in safeguarding the rights and autonomy of a terminally ill individual seeking an assisted death. By ensuring that the method of administration is clearly explained, we empower patients to make an informed, autonomous decision about the way in which they wish to end their life.

Danny Kruger: It is a pleasure to serve under your chairmanship, Dame Esther. *[Interruption.]* You are Dame Esther, aren't you?

The Chair: I am not.

Danny Kruger: Are you not? That is an extraordinary oversight. That must be rectified as soon as possible—I am sure it will be. I will speak in support of the amendment in my name and those in the names of the hon. Member for York Central and my hon. Friend the Member for Solihull West and Shirley. As he has explained, amendment 93 requires doctors to specify what drug “is to” be used, not just “might be” used. My amendment 362 states that there must be clarity on the complications and risks involved in the procedure. Amendment 305 states that we must be clear about “other effects in addition to death.”

Amendment 306 discusses escalation in the event of complications.

We have discussed informed consent previously. We have identified that the General Medical Council's guidance on critical information that patients must receive has been selectively placed in clause 7. Of the five areas that the GMC says should usually be conveyed to patients, two were omitted: first,

“uncertainties about the diagnosis or prognosis, including options for further investigation”,

and secondly,

“the potential benefits, risks of harm, uncertainties about and likelihood of success for each option, including the option to take no action. By ‘harm’ we mean any potential negative outcome, including a side effect or complication.”

It is not being explicitly stated that doctors should communicate that to patients.

Telling a patient exactly which drug or substance will be used to end their life, and its likely side effects, is critical if they are to have informed consent. Full understanding requires the patient to know the specific drug that will be used. It lets the patient grasp the method, its effects and its finality. Patients deserve to know how the drug will work; what its administration will be, whether oral or intravenous; the time it will take to have an effect, whether that is minutes or hours; and the other sensations that will be felt. It is difficult to say that we can convey that information without being specific about which drug will be used.

[Danny Kruger]

In other countries, for instance in the Netherlands, the criteria require that patients are fully informed, including about the drug that will be used and the method. In Oregon, the Death with Dignity Act similarly requires discussing the prescription of the specific drugs. That equips the patient to find out more, should they wish to do so, and to ask questions. A patient with a terminal disease needs to know the drug to confirm if it aligns with his or her wish for a peaceful death—it is not just an abstract agreement to die, trusting that medicine will do the trick.

An important consideration to note is age. Dr Jessica Kaan, writing in the *Journal of Aid-in-Dying Medicine*, found

“a clear and linear correlation between younger patient age and longer times to death. Older-age patients have, on average, shorter deaths.”

It is important for clinicians to be aware of that research. She continued:

“Clinicians should consider and discuss this information as part of informed decision-making...with patients.”

They can do that only if they are aware of what the drugs will be.

2.30 pm

Amendment 305, in the name of the hon. Member for York Central, seeks to ensure that the medical practitioner discusses possible effects arising from the substance used to end the person's life. Clause 9 currently states that the assessing doctor must

“explain to and discuss with the person being assessed...the nature of the substance that might be provided to assist the person to end their own life”.

The amendment would introduce a further requirement for the practitioner to explain and discuss

“any other effects in addition to death.”

That is important, because there will not always be safe, pain-free, curated deaths, as I am afraid are sold by campaigners for this law. We need to start with the uncertainties, and the fact is that assisted dying does not offer a risk-free death. In Oregon between 2012 and 2022, there was an 11% complication rate. Reported side effects included regurgitation, seizures, and surviving lethal drugs. Nine patients have regained consciousness after taking assisted suicide prescriptions. Half of all deaths in Oregon took over 53 minutes, which was the median time. The longest took 137 hours. It is not guaranteed that someone will have an uncomplicated, easy or indeed pain-free death.

Complications have been reported in other jurisdictions as well. In 2019, Washington state stopped reporting data relating to complications, despite multiple complications being reported in the years before then. None the less, complications including regurgitation, seizures and regaining consciousness have all been recorded since implementation in Washington. In 2018, there were eight recorded complications in Washington, all of which were regurgitation as a result of the ingestion of lethal drugs.

Dr Simon Opher (Stroud) (Lab): I thank the hon. Gentleman for tabling amendment 362. Does he accept that Australia, for example, has a very different regime

from America? In Australia, people are given pentobarbital, which has not failed on any occasion—in any of the 2,500 treatments since assisted dying was legalised. In America, people are not allowed to use that; instead, they use another cocktail of drugs, which is not as ideal and can have other side effects. May I also say that I am not sure whether it is totally relevant to discuss the problems of a drug given in America in this context? We are discussing just putting down in law what the doctor is obliged to say to the patient.

Danny Kruger: I am grateful to the hon. Gentleman for those points because he helps me to direct my argument. It is essential to discuss the evidence from abroad about the complications that arise from assisted suicide, but the evidence is very patchy: we know what we know, but we don't know much. There is a complete dearth of evidence, including in Australia. When Australians gave evidence to the Committee, it was put to them, accurately, that there is a great lack of adequate data gathering in Australia, as in other countries too. So when he says there have been no complications in Australia, what he means is that there have been no reports of complications in Australia. As we always need to point out, absence of evidence is not evidence of absence.

Kim Leadbeater: That question was indeed put to the experts from Australia, but actually they were quite clear that there is a huge amount of evidence. Indeed, there is a very robust reporting mechanism in Australia—the best in the world, I suggest—so there is a huge amount of evidence from that jurisdiction.

Danny Kruger: Let us not rehash the conversations that we had in the evidence sessions, but I would advise Members to review those conversations. Indeed, there is further publicly available evidence, which I am happy to share, of the problems with data collection in Australia, as in other countries. To the point of the hon. Member for Stroud about the evidence of complications that arise in other jurisdictions being irrelevant to our discussions, because of the lack of clarity in the Bill about what drugs would be used to bring about the assisted suicides that we are proposing to legalise, all we can do is rely on evidence from abroad, and I will insist on doing so.

As well as questions about complications and side effects, there is also a crucial question about how long it takes to die. In Canada, a study demonstrated that in 5% of cases, patients experienced a prolonged time to death. Another study showed that 50% of cases in Canada with available data—again, there is a lack of data—were unsuccessful within 60 minutes. It is clearly common in other countries for death to take up to or more than an hour.

The Canadian Association of MAiD Assessors and Providers—the people who do it—acknowledged that patients who ingest assisted suicide drugs can experience burning, nausea, vomiting and regurgitation. I am not saying that that always happens, or that it happens in the majority of cases, but it clearly happens. It is therefore appropriate for patients to be properly informed of those risks, if they are associated with the drugs that will be used. We do not know what those are going to be at this stage.

In the Netherlands, where assisted dying or assisted suicide has been legal for 20 years, a third of people with assisted suicide deaths experience some adverse symptoms such as pain, restlessness, shortness of breath, secretions, nausea and vomiting—that is, a third of people experienced some of those distressing side effects as they died, so it is very far from a guarantee of a pain-free death. It is vital that people considering an assisted death are aware of those possible effects, in addition to the primary effect of the drugs which is, of course, to kill them.

There is also a question about the method of administration. People should know that where regimes use the intravenous route of a short-acting anaesthetic, that is also not without problems. People would understand, and potentially argue for, having an anaesthetic as the first part of the cocktail of drugs that will be administered, but evidence from abroad demonstrates that the anaesthetic induction agent, which is usually propofol, a drug that puts people to sleep before surgery, can wear off rapidly in some people, particularly in younger patients, those who are less ill and those who are larger in size.

In around two thirds of assisted deaths with administrations that use that technique, that anaesthetic is rapidly followed by a paralysing agent. The patient cannot then move a muscle and, unable to breathe at all, they die of asphyxia. Unfortunately, there has been no monitoring of patients while they are given those drugs to ascertain whether they regain consciousness as they die. They cannot move a muscle, so they cannot signal distress. We are unclear what the experience of the dying person is beneath the apparent calm that has been induced in them by the paralytic drug that they have been given.

We do know, however, that similar combinations have been used in judicial executions. Post mortems have shown, as reported in *The Lancet* in 2005, that the level of anaesthetic induction agent in the blood at the time of death was lower than that required for surgery in 88% of executed inmates. Shockingly, in 43%, the concentrations were consistent with awareness, meaning they may have suffered during the execution.

Dr Opher: The hon. Gentleman is bringing up lots of rather horrible stories about assisted death. That is why, in Australia, Switzerland and Holland, they have decided, instead of using the regime that he is talking about, to use pentobarbital. At 15 grams, that has not had any failures—no one has woken up. The only real side effect that people complain of before they go to sleep, which happens very quickly, is that it is very bitter. One of the reasons why Dignitas uses it is that it is so effective and it does not have those effects. I would push back on some of those scare stories.

Danny Kruger: I am afraid to say that the whole debate about assisted dying is replete with scare stories. The hon. Gentleman says that they are descriptions of horrible events, but that is the situation that we are dealing with. We are here to try to pass legislation that is designed to avert horrible deaths. I am absolutely committed to that as well, but the evidence from abroad shows that people can also have a horrible death with assisted dying.

The hon. Gentleman points to Australia, but the evidence from Western Australia in particular is that over 4% of assisted deaths reported complications. He

might be right that it is a better regime than that used in the United States, but even there complications occur. We do not know yet what the regime will be here, but I am alerting the Committee to the genuine danger of an assisted dying regime that induces very unpleasant results for patients.

Jack Abbott (Ipswich) (Lab/Co-op): The hon. Member may be surprised to hear that I am inclined to support his amendment 362 and amendment 142 tabled by my hon. Friend the Member for Broxtowe, not because of, in the words of my hon. Friend the Member for Stroud, the scare stories or the examples that the hon. Member has been giving, but predominantly because of what the amendment says on the tin: that a person must be given a full explanation of the risks of complications and how a substance should be administered. As I have said a number of times in Committee—

The Chair: Order. Can I just check that this is an intervention?

Jack Abbott: It is an intervention, Ms McVey. My plea to the hon. Member is to focus on exactly what the amendment states. I appreciate all the stories and examples that he wishes to make, but it is important to reflect on the words of the amendment. As I said, I am minded to support it.

Danny Kruger: I am grateful to the hon. Member for his intervention.

Amendment 306, tabled by the hon. Member for York Central, addresses the question of what to do in the event of complications. I recognise that clause 9 states that that must be discussed, which I welcome. I think, though, that there is a significant absence that this amendment would address, which is what to do in the event of complications—specifically, which intervention would be appropriate.

Here we get into a very difficult area. I personally find it difficult to understand a way out of it, because it is a consequence of the sort of legislation that we are considering: what do we do when complications arise? Specifically, what do we do when the patient does not die and is still alive some hours later, possibly in distress? I have cited evidence about some of the complications that occur and the prevalence—for example, that 10% of such people in Oregon experience complications, including some who simply wake up again. We need to resolve this. On explaining possible side effects and complications, under the Bill as it stands none of the declarations that are signed by the doctors or the person requesting assistance confirm in writing that the criterion has been met for proper communication, so that is one concern.

My more substantial concern—I will finish with this—is that at the moment the doctors have to explain the complications, even though we do not know what the drugs are going to be yet, but they cannot discuss or decide with the patient what they would do in the event of complications. We know that the doctor must be present at the end or in the next room, but can they halt the process if complications arise—if the patient wakes up or is exhibiting signs of distress? That would be against the last known wishes of the patient who had

[*Danny Kruger*]

said that they wanted to go ahead with the death. Should the doctor expedite the death knowing that that is what the patient theoretically wanted? Of course not, because that would be euthanasia; it would be the doctor actually killing the patient, which is illegal under the Bill. Do they stand by and do nothing at all, which goes against the doctor's obligations to address symptoms and illness in a patient? If the patient is fitting or vomiting, the doctor would normally clear their airways. Should they do that, knowing that that might bring the patient back to life—that it might resuscitate them and stop the assisted death?

When we debate clause 18, we will discuss the process of the assistance that the doctor gives, but we are obliged, when we come to debate the Bill fully, to choose between three options. We could allow complications without any guidance, which is what the Bill does; that raises all sorts of challenges, and practical and ethical concerns, for doctors. We could stipulate that the patient should be revived, perhaps if a certain degree of distress is witnessed or if the patient is still alive after a certain period of time. Finally, we could allow euthanasia and say that, in that event, the doctor should be authorised to expedite the death. I do not know what the option should be. That is a question that a doctor would have to face in reality, in the bedroom of a patient who is exhibiting complications. I do not know what to do, but I do not think we should be proceeding with this Bill. Those who do believe in it have to answer this question: what does a doctor do if a patient is exhibiting distress and not dying—do they bring them back to life, expedite their death or do nothing?

2.45 pm

Sean Woodcock (Banbury) (Lab): I rise to speak in support of amendment 362, tabled by the hon. Member for East Wiltshire, which requires the registered medical practitioner to explain and discuss the nature and the risk of the lethal drugs. There is a bit of a theme to the amendments I have tabled so far: they have almost all been about giving the patient more information. The promoter of the Bill, my hon. Friend the Member for Spen Valley, is quite right in focusing on the importance of the patient's autonomy. I absolutely believe in and value that autonomy—I am sure everybody across the Committee does so too—but true autonomy is linked to having access to good quality and accurate information. It can severely impact someone's autonomy if they do not. This Bill states that the person must have an informed wish to end their own life. I believe that this must explicitly include an understanding of the nature of, and the risks of, the lethal drugs involved in assisted dying.

This Bill's passage through this place has led to lots of conversations and a greater awareness of the issue of death across the country. Morbid as that is, it is a really good, healthy thing that people are talking about end of life—something which we will all encounter—and that is welcome. The debate on assisted dying has made many people concerned about the nature of death and the choice that they might face at the end of their life. Inevitably, for some, the impression has been given that an assisted death uniformly provides a pain-free alternative. I accept that that is absolutely what the promoter of the

Bill, and those in support of it, are aiming for—that is not in question—but we have heard from the hon. Member for East Wiltshire about issues with that, and that there have been exceptions in places where such laws have been put in place. I also point to the evidence of James Haslam, a consultant in anaesthesia and intensive care medicine, who put in his written evidence to the Committee that assisted dying

“does not guarantee a painless, peaceful and dignified death.”

The key word there is “guarantee” because, unfortunately, some people who ingest the prescribed lethal drugs do experience distress and complications. In the Netherlands, a high dose of barbiturates is used for all administrations of lethal drugs, and in two thirds of cases—the majority—the person dies within 90 minutes, but a third of cases do take longer and can take up to 30 hours. Complications include difficulty swallowing the whole prescribed dose, vomiting, and in some cases re-emergence from coma. I do not accept that this is an incidental concern. Vomiting affects up to 10% of assisted deaths by oral administration in the Netherlands. There is no easy way to research the efficacy of these drugs on humans given their lethal effects, and as a result there is no regulatory authority in the world that has approved these drugs to be used for this purpose. The data that we have shows that these complications take place in all jurisdictions that have assisted dying. As the hon. Member for East Wiltshire has already mentioned with respect to Oregon, between 2012 and 2022, 11% of the time there were complications.

These complications raise important ethical and medical questions for the doctor and for the terminally ill person. Of course, by the time complications occur, it is too late to discuss or reconsider the person's options. That is why it is essential that the registered medical practitioner has already explained and discussed with the person the risk and nature of the lethal drugs. Choice is about not simply having options available, but understanding them. That goes to the point I made at the beginning: autonomy is absolutely linked to the quality of the information that someone has been given in order to make that autonomous choice. That requires the registered medical practitioner to explain the full risk and the nature of the possible complications from the lethal drugs.

The General Medical Council sets out five points of guidance for doctors on how they should hold a dialogue with their patients about reaching a decision. Three of the five GMC points are already covered by the Bill, but two are excluded: uncertainties about the diagnosis or prognosis, including options for further investigation; and the potential benefits, risks of harm, uncertainties about and likelihood of success of each option, including the option to take no action.

I can see no good reason why we would not want doctors to be entirely honest with patients who are considering assisted dying, even to the point of saying that the vast majority of people will not have any complications, but there is a chance. Personally, I see no issue with that, or why there should be. Doctors should give their patients that information; not only is that good practice—as we heard from my hon. Friend the Member for Stroud and the hon. Member for Solihull West and Shirley—but, as the GMC guidance makes it clear, they should do so because we should not give people with serious illnesses a false picture of what assisted death means. I link back to the emphasis on the word “guarantee”, as per the written evidence I quoted.

Amendment 362 would affirm the commitment of the Bill's promoter, my hon. Friend the Member for Spen Valley, to upholding medical standards. It would clarify the full responsibilities of the registered medical practitioner under the General Medical Council guidelines. Perhaps more importantly, it would put the terminally ill person in a better position to understand fully the options available and the associated risks.

In Committee, we have heard frequently that the Bill is about expanding choice and autonomy at the end of life. To act autonomously, terminally ill people need—I emphasise this again—to understand what they are facing as best they can, with the best and most accurate information available to them as early as possible. That is why I support amendment 362, and I urge the Committee to do so, too.

Naz Shah (Bradford West) (Lab): I rise to speak in support of amendments 305 and 306, in the name of my hon. Friend the Member for York Central.

Under amendment 305, a doctor would have to explain what effects the medicines would have as well as death. I appreciate the points made by the hon. Member for Solihull West and Shirley, and what other Members have said about effects and side effects. I would first say: we do not know the side effects. There is no research into any of the drugs being used for the purpose that we are looking at—for assisted suicide, euthanasia or whatever whichever jurisdiction calls it. We therefore cannot give a clear view of what the side effects are; they are largely unknown, as I understand it.

In addition, there are different drugs. My hon. Friend the Member for Stroud mentioned one drug, pentobarbital, which has caused huge concern. I did not know about the issue in Australia, but I know the evidence from death row in America, after Texas started using pentobarbital; there have been huge concerns and lawsuits there. I am happy to be referred to other evidence. In some cases, the effect of the drug has been described as akin to suffocating or even as being waterboarded or drowning.

Concerns have been expressed about the use of such drugs in other jurisdictions. I agree with the hon. Member for East Wiltshire that we should be looking at all such jurisdictions, because this is something new for us. If we are to learn from other jurisdictions where assisted dying has happened and it has been okay for people, whether that is Australia or others, it is equally right that we hear from those jurisdictions where things have not gone right or to plan. That is important.

Clause 9(2)(b) states:

“The assessing doctor must...explain to and discuss with the person being assessed”,
among other things,

“the nature of the substance that might be provided to assist the person to end their own life (including how it will bring about death)”.

Amendment 305 would instead require that the assessing doctor explain to and discuss with the person being assessed the nature of the substance that might be provided to assist the person to end their life, including how it will bring about death and any other effects it would have in addition to death. That is really important.

There are several relevant things that patients should know if they are to be able to make an informed choice. First, they should have as clear an idea as possible what

the experience of taking the lethal drug is like. In some countries where people undergo assisted dying, they swallow a cocktail of drugs. Patients whose assisted dying process did not succeed have said that the drugs are bitter tasting. If this is to be the method used in assisted death in this country, applicants should be aware of that, because some people do not take tablets—they just will not do it. If other methods are to be used, doctors should inform patients of what the experience will be like to the best of their knowledge.

The second thing assisted death applicants should know is that they may suffer complications. We know from countries and states that have assisted dying that some patients undergo complications during the process. It has been said before, but I will repeat the point, because it is really important: there can be complications. People may vomit or undergo seizures. One assisted dying recipient took 137 hours to die. That is five days and 17 hours.

We do not know the full number of patients who have died very lengthy deaths in Oregon, because the lethal drugs are self-administered, usually with no doctor present, but just because there is no report saying that things have gone wrong, it does not mean that everything has gone right. Oregon also found that at least nine patients failed to die from lethal drugs. We do not know whether that is the total number—again, because the assisted dying applicants in Oregon self-administer drugs. We can say with certainty that complications exist, although, unfortunately, gaps in the data mean that we do not know how common they are.

Amendment 306 would change the duties of a doctor present during the assisted dying process. Currently, clause 9(2)(c) states that the co-ordinating doctor must discuss with the person

“their wishes in the event of complications arising in connection with the self-administration of an approved substance”.

If the amendment were accepted, the clause would state that the co-ordinating doctor must discuss with the person their wishes in the event of complications arising in connection with the self-administration of an approved substance

“including the escalation of medication intervention”.

This is a point of great importance, both for the person seeking assisted dying and the doctor, who would have to be present for the process. It would mean that the applicant and the doctor would have to think through what they wanted to happen if the applicant did develop complications. Should the doctor at a certain point act to revive an applicant—for example, if the person seemed to be suffering extreme pain as a result of a lethal drug? Alternatively, should the doctor remain as an observer and, if it were clinically possible, someone to administer further pain-relieving drugs? Not doing anything is clearly not an option. Both courses of action might seem harrowing to the person seeking assisted dying, but it is something that they should clearly discuss with the doctor, because these situations could really happen.

There are clearly no easy answers to these questions, but if applicants are to take an informed choice over assisted dying and if we want to provide autonomy, they must know that these questions exist and they must discuss them with their doctors. We have talked a lot about autonomy for people with serious illness. Those people will not have autonomy unless they are

[Naz Shah]

informed in accurate detail about the possible outcomes of assisted dying, and these amendments would ensure that.

Ultimately, if someone takes a drug to end their life, they will either die or not die and be left in a compromised state. Are they then escalated to A&E, because leaving them in that state is not an option for any doctor—or does the doctor proceed to administer more drugs? What does the doctor do?

Kim Leadbeater: My hon. Friend raises a really important point. As clause 9 says, the doctor has an obligation to discuss with the person their wishes in the event of complications, so that conversation would have happened with the patient. To be clear, the doctor cannot intervene to expediate the patient's death. That is very clear in the Bill.

3 pm

Naz Shah: I thank my hon. Friend for her intervention. Actually, clause 9(2)(c) covers the complications but does not state clearly what would happen in the event of those complications. Would the patient still want to carry on down that path?

Kim Leadbeater: To be clear, it does say “discuss with the person their wishes”.

That includes whether they would want the doctor to call an ambulance if things got complicated, or whether they would want to be left—so the doctor would discuss with the patient their wishes in that situation. Fortunately, it does not happen very often.

Naz Shah: Yes, fortunately not. I am not convinced that the clause covers it. I will go back to that, but I have just read it because the hon. Member for Solihull West and Shirley raised it and I support his amendment, and somebody else raised it earlier.

I am not convinced that the complications are covered, because the clause does not set it out. In the usual sense, complications are side effects from medications. We have research and literature given to us and we understand the potential side effects. In this instance, we do not have a yardstick. I do not know whether the Minister can speak about the Government's intentions—it would be helpful to have an impact assessment—and whether any research has been done in this area.

I am not convinced that clause 9(2)(c) actually covers this point, and I think the amendment would make the Bill much stronger. Ultimately, these drugs have not been tested—and for a very good reason, because they lead to death. We are in uncharted territory. When we are doing things that we have not done before, we cannot just pick and choose what we apply an analogy to. We need to be careful. We really need to consider the options to make this clause in particular much stronger.

Jack Abbott: I completely understand what my hon. Friend is saying about what may need to happen in respect of medical intervention, but I gently point out that the amendment would not cover that. It does not spell out in any way, shape or form what a medical

intervention would look like. It says that there needs to be a random discussion, but it does not lay out any sense of the medical intervention. I do not see how the amendment will do what my hon. Friend is looking for.

Naz Shah: I thank my hon. Friend for his intervention. As drafted, the Bill does not include effects. All it says is “complications”. It does not include the potential effects of the drugs that will be used. That is how the amendment would strengthen the Bill.

Danny Kruger: We might appear to be dancing on a pinhead, but this goes to the heart of the question about what on earth we do in the event of complications. As the hon. Member for Spen Valley says, the Bill as drafted says that discussions should be had about wishes in the event of complications. That might simply be, “Do you want us to call somebody? Do you want us to try to make you more comfortable?” The amendment would require a discussion of escalation—what further medical interventions might be appropriate in the event of complications arising. There is a huge question for us, which we have not yet had answered, about what on earth should be the range of options for a doctor. The importance of the amendment is to specify that there may be further medical interventions in the event of complications. Does the hon. Lady agree that that is the value of it?

Naz Shah: I completely agree with the hon. Member. He said it much better than I did in response to my hon. Friend the Member for Ipswich, so I thank him for that.

Dr Opher: I will be brief, because I think we have discussed this enough. I totally agree with my hon. Friend the Member for Banbury. Patients need to be informed about the procedure—there is no argument about that—and I approve of the first three amendments in this group.

Let me say a bit about data. I met the pharmacist from Australia who is in charge of assisted dying and he had data on 2,500 assisted dying patients. The data is clear: all the patients died—no one survived. Almost everyone immediately goes to sleep, which can be a problem, because if they do not take all the medicine, it causes a slight difficulty that I will explain in a minute. Fifty per cent died within 30 minutes, 70% within an hour and 95% within two hours. One patient survived for 21 hours because she had not taken the full dose because she fell asleep; that is a potential problem. All these things should be described, and are routinely described to patients in Australia.

The first thing, then, is that we have plenty of data. The second thing I want to say is that we are dealing with the end of life. I have sat with patients as they have died; I have sometimes seen people being a little bit sick. We know how to cope with that. We do not need to specify how we cope with someone who is dying, because we have done it many, many times. I do not think amendment 306 will add anything to the Bill because it is part of what doctors do normally.

Naz Shah: I am genuinely trying to understand and would like my hon. Friend to clarify. He says that doctors generally do this anyway, but the difference is

that, in this instance, somebody has chosen to die. Generally, when doctors do anything they are trying to save patients, are they not? The general rule of thumb is that a doctor saves lives. In this instance, they are not doing that because the patient wants death.

Dr Opher: We are not doing that in situations of terminal care—we are allowing someone to die. We are very experienced in allowing people to die. I have done it for 25 years. It is not a new skill just because we have the assisted dying element. We deal with the situation as it arises.

Danny Kruger *rose*—

Dr Opher: I had virtually finished, but I give way.

Danny Kruger: The hon. Gentleman puts his finger on a key point. The hon. Member for Bradford West is absolutely right: surely the hon. Gentleman acknowledges that there is a difference between allowing somebody to die and giving them lethal drugs that make them die. I am sure he would acknowledge the practical, if not the moral, distinction between the two. He says he has lots of experience of helping people to die; has he ever had experience of watching somebody die after administering them lethal drugs? No.

Dr Opher: No, I have not, because that is currently illegal—this Committee is about changing that—but I have sat with patients who have slowly died. It is not about whether we get an ambulance; we know we do not do that. We are allowing the patient to die, and if something happens that involves having to help them, we just do it. We do not need to specify that in the Bill: it is part of normal medical practice.

Jack Abbott: I will be brief, as I have already alluded to my support. I put on the record my support for amendment 93. There has not been a lot of debate on it because it is a fairly straightforward proposal.

There has been a lot of discussion. Members on both sides of the Committee have spoken in defence of the medical profession in respect of huge parts of the Bill, although they should not have to. We have of course seen occasional bad practice, as we do in all professions, but we should take a moment to reflect on the dedication, diligence, hard work and expertise of medical professionals in everything they do. This debate has on occasion almost presented this as a 50:50 choice between good doctors and bad doctors. I think we would all agree that although we want to put in the right safeguards, that is not the case at all.

I have made this point a number of times, but I do not want to accept amendments that spell out all the rules and regulations so that every doctor has to go to the nth degree all the time. As my hon. Friend the Member for Stroud has said eloquently on a number of occasions, it is already in their codes of conduct, working practice, training and everything else. However, on occasion we cannot be satisfied that something is a given. For that reason, particularly in respect of amendments 142, 362 and perhaps 305, if we say that

“the nature of the substance that might be provided to assist the person to end their own life (including how it will bring about death)”

must be discussed, it is not a huge leap to say that we should also spell out how it may be administered and the possible risks and complications that come with that. As I have said, I do not think it will create any unintended consequences. I do not think it puts the full rulebook on the face of the Bill. If we are stipulating how it will bring about the death, it is not a huge leap to also talk about the other side effects.

Cutting through some of the stories, and everything else we have heard this afternoon, we should be considering what the amendments seek to do—what they say on the tin, as it were. We should be asking doctors to have the conversations, although I am absolutely sure that, as my hon. Friend the Member for Stroud said, those conversations will happen naturally anyway. I do not think there is anything harmful in the particular amendments, as we have discussed today.

Finally, on amendment 306, I understand the points that my hon. Friend the Member for Bradford West and the hon. Member for East Wiltshire made. To be totally honest, I fail to see how the amendment satisfies the arguments they were trying to make, as powerful as those arguments are. It does not solve the issue they are looking to solve; I do not think it answers any of those questions. For that reason, I will not support amendment 306, but I am minded to support the other amendments in the group.

Stephen Kinnock: Amendment 93 relates to the discussion during the assessment that the co-ordinating doctor and the independent doctor are required to have with the person. The amendment would require that each of those doctors, during their assessment, must discuss the nature of the substance that “is to be provided” to the patient to end their life, rather than the substance that “might be provided”.

On amendment 305, clinicians in all areas are expected to work with patients to make decisions about their care and treatment as part of a shared decision-making process, including by discussing the risks, benefits and possible consequences of different options. The Committee may wish to note that the GMC’s “Good medical practice” states that when discussing a patient’s condition doctors must discuss with patients

“the potential benefits, risks of harm, uncertainties about, and likelihood of success for each option.”

Naz Shah: That is the very point I am struggling with. Generally speaking, the GMC guidelines are absolutely right, and doctors are saving lives and making the person better. In this instance, somebody might have complications and they might vomit, for example—that happens a lot because people are unconscious. What does the clinician then do? Do they proceed with an assisted death, or do they get the person into A&E? I am trying to understand the answer to that question, and I hope the Minister can respond.

Stephen Kinnock: My hon. Friend will know that the Bill states that the assessing doctor must discuss with the individual

“their wishes in the event of complications”,

which could include medical interventions. What is also absolutely clear is that the Bill precludes the doctor from making any intervention, vis-à-vis the patient,

[Stephen Kinnock]

that may lead to the patient's death. The Bill is based on self-administration, not on administration by the doctor. By definition, the actions that can be taken by the doctor are things like calling an ambulance; they would not be things like escalating the substance that has been used in order to bring about the death of the patient. I hope that is clear to my hon. Friend.

Rebecca Paul (Reigate) (Con): I thank the Minister for that explanation. What happens if the patient sets out in advance that they want no interventions? What if they have said, under the clause as the Minister laid out, "In the event of complications, if I am vomiting and in distress, I want no interventions", but when that happens the pain and distress are at a different level and they are begging the doctor to help them? What does the doctor do in that instance?

Stephen Kinnock: The key point, and what takes primacy above all else, is the professional judgment of the doctor. I commend the words of my hon. Friend the Member for Ipswich about every doctor in the profession; he reinforced the point about the immense skill, professionalism and judgment of clinicians and medical professionals across the length and breadth of our country. Clearly, in a crisis situation such as the one the hon. Lady described, the professional judgment of the doctor would kick in and they would take whatever action is necessary. If a patient stipulated what they wanted to happen in the event of complications and something like the hon. Lady just described were to happen, I do not think the doctor would accept those conditions.

3.15 pm

Rebecca Paul: I thank the Minister for that clarity. Does he think it would be worth while setting that out in more detail, in order to protect doctors and make it really clear what would happen in such a situation? This would be an unprecedented, unique and very new process, and I can imagine substantial moral injury to doctors from being put in that predicament if we are not very clear about what they are required to do and what they are required not to do.

Stephen Kinnock: The basic position of the Department of Health and Social Care and, by extension, the Government is that we rely on and trust our medical professionals to make judgments and do the right thing. They take the Hippocratic oath, so they are going to do what is right for the patient in the circumstances of their interaction with that patient. That is set out in guidance and in the corpus of law that we already have. There is a risk of destabilising the system by introducing measures that may well cause confusion and muddy the waters when the waters do not need to be muddied.

Danny Kruger: I am afraid that the waters are pretty muddied by the Bill. It states a direct contradiction of the Hippocratic oath, which requires doctors to save people's lives and do nothing to bring about their death—including giving them lethal drugs. It is right there in the Hippocratic oath. There is obviously a real challenge if somebody has had assisted death drugs and then exhibits complications—if they are not dying quickly,

for example, or are showing distress. Normally, the obligation on a doctor would be to relieve their symptoms and try to bring them back to life. Is the Minister saying that is what they should do—and if not, what should they do?

Stephen Kinnock: There is a debate to be had about the Bill's effect on support for a patient. I am not here as a member of the Government to comment on the rights and wrongs of that, but those who support the Bill would argue that a doctor participating in and facilitating assisted dying is actually helping the patient and is, therefore, absolutely aligned with the Hippocratic oath, which is to do no harm. That is in the eye of the beholder, as I am sure the hon. Member would agree, and it is not my job to get into the whys and wherefores of the philosophy that underpins the Bill.

The Chair: Order. If we could come back to the amendments, that would be helpful.

Stephen Kinnock: I will do so with huge pleasure—thank you, Ms McVey—but I would be more than happy to take up that discussion with the hon. Member for East Wiltshire at another time.

On amendment 142, it is worth noting that options for the method of administration of the substance may change if a patient's condition alters as they progress through the process set out in the Bill.

Amendment 362 would add to the list of matters that must be discussed at the first and second assessments by the co-ordinating and independent doctors. It would require the assessing doctor to include an explanation and discussion of not only how the approved substance will bring about death, as set out in the Bill as drafted, but the risk and nature of any possible complications, including pain. The Committee may wish to note that the GMC's "Good medical practice" already states that doctors must discuss with a patient

"the potential benefits, risks of harm, uncertainties about, and likelihood of success for each option" when discussing their condition.

As it stands, the Bill specifies that the assessing doctor must discuss the individual's "wishes in the event of complications",

which could include medical interventions. However, amendment 306 would go further and specify that medical intervention must be discussed.

I hope those observations were helpful to the Committee.

Kim Leadbeater: I will start with amendment 93 tabled by the hon. Member for Solihull West and Shirley. He made a really important point about the language in the clause, and I am very happy to support the amendment.

It is quite clear that, across the Committee, there is no disagreement that a terminally ill person requesting assistance to shorten their death should be given all the information necessary to help them make the clear, informed and settled decision the Bill requires. That should include an explanation of the drugs that are likely to be used—bearing in mind that there may be more than one option available to the person when the time comes, depending on their medical circumstances—and how they would be administered. As such, I am minded

to support amendment 142, tabled by my hon. Friend the Member for Broxtowe. Amendments 142 and 93 both provide helpful clarity for the Bill.

There are good intentions behind amendments 305, 306 and 362, but I am confident that they are already covered by clause 9(2)(b)(iv) and clause 9(2)(c). I do, however, take on board the point made by the hon. Member for Solihull West and Shirley about the concept of side effects. Going forward, it might be helpful to look at that use of language. To conclude, I am minded to support amendments 93 and 142.

Dr Shastri-Hurst: You will be delighted to learn that I have nothing further to add to this debate, Ms McVey.

Amendment 93 agreed to.

Amendment proposed: 305, in clause 9, page 6, line 3, after “about death” insert

“and any other effects in addition to death.”—(Danny Kruger.)

This amendment would require the assessing doctor to explain effects the provided substance would have in addition to death.

Question put, That the amendment be made.

The Committee divided: Ayes 9, Noes 13.

Division No. 44]

AYES

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

NOES

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

Question accordingly negated.

Amendment made: 142, in clause 9, page 6, line 3, after “death” insert

“and how it will be administered”.—(Juliet Campbell.)

This amendment requires the assessing doctor to explain and discuss with the person how the substance that might be provided to assist the person to end their own life will be administered.

Amendment proposed: 362, in clause 9, page 6, line 3, after “death” insert

“and the risk and nature of possible complications including pain”.—(Danny Kruger.)

This requires the doctor to explain the risk of possible complications to the person.

Question put, That the amendment be made.

The Committee divided: Ayes 9, Noes 13.

Division No. 45]

AYES

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

NOES

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

Question accordingly negated.

Danny Kruger: I beg to move amendment 307, in clause 9, page 6, line 18, leave out from beginning to “advise” and insert

“unless the assessing doctor has concluded in good faith, that this would not be in the person’s best interests.”

This amendment would require the assessing doctor to inform the person’s next of kin that the person wishes to seek assistance to end their own life unless it is not in the person’s best interests.

The Chair: With this it will be convenient to discuss amendment 308, in clause 9, page 6, line 20, at end insert—

“(g) If that doctor considers that it is not in the person’s best interests under paragraph (f), this decision and the doctor’s reasoning must be documented.”

This amendment is consequential to Amendment 307 and would require a decision that it is not in the person’s best interests to inform their next of kin to be documented with its reasoning.

Danny Kruger: Amendments 307 and 308 concern the question of who should be informed when an application has been made or when an assisted death has been approved, and at what stage it is appropriate for family members or next of kin to be informed. During the debate on clause 8, we discussed whether a patient should be asked to state whether they have informed their family.

I think it is appropriate to have a stronger requirement for doctors to notify a patient’s next of kin. Amendment 307 would remove the phrase

“in so far as the assessing doctor considers it appropriate,”

leaving that they should

“advise the person to consider discussing the request with their next of kin”.

Amendment 308 is either supplementary to amendment 307 or could work in isolation, because it states:

“If that doctor considers that it is not in the person’s best interests under paragraph (f), this decision and the doctor’s reasoning must be documented.”

These are important amendments because they communicate the truth that it is not just the patient who is affected by an assisted death; I suggest that others are affected. Conversely, behind that apparently autonomous individual patient, who might think they are acting with absolute autonomy and without reference to others, there may somebody who is exercising undue influence on them.

To me, these amendments speak to the essential tension at the heart of the Bill: whether we are talking about isolated individuals or recognising the reality that no man or woman is an island. We are all connected and we all have obligations, whether as a society to the people who will be involved in the administration of the procedure or, more directly and obviously, to family

[*Danny Kruger*]

members or to the patient themselves, to be sure they are not subject to undue influence. There are many ways to try to identify undue influence, but one important one that would be addressed by this amendment is the opportunity to involve a person's wider family in the discussions leading up to their assisted death.

3.30 pm

I want to read out some of the short testimonies we have received—again, I do not want people who have submitted evidence to feel that their efforts have been in vain and that it has gone into a black hole. Some of us, at least, have digested it, and I want to repeat some of it for the benefit of the Committee. Let me quote Anna Bossong:

“I was at home late one evening in London when I received an unexpected call from a nurse at my mother's nursing home in Australia. She said to me “I am calling from your mother's room. All her friends are around her bed and are singing as they see her off. She has a morphine pump in her hand and I am helping her to pump it.

It is an understatement to say that I was shocked as this had come totally out of the blue.”

She goes on to explain the efforts she made, and the enormous trauma she suffered, as a consequence of this event happening without her prior knowledge.

Alicia Duncan also gave evidence to us:

“My mother informed us of her scheduled MAiD”—

that is a reference to the Canadian medical assistance in dying system—

“less than 48 hours before her initial appointment, leaving my sister and me scrambling to respond. Over the next five days, we used every legal tool available, including obtaining a warrant under the Mental Health Act, to try to keep her alive through all legal means. She was admitted to a psychiatric unit but released after 48 hours and died without our knowledge just four hours later. Both of us have been diagnosed with Post-Traumatic Stress Disorder (PTSD) as a result of these events.”

I am afraid to say that there are a number of terrible examples of this happening in jurisdictions where assisted dying is legal, and such things would be possible in our country too. I draw the Committee's attention to the points made by the hon. Member for York Central, who tabled this amendment, about a constituent whose parent had an assisted death without her knowledge and about the trauma she suffered because she felt that it was the wrong thing to do and that the medical team should have had more knowledge of the circumstances surrounding her parent's life.

We had evidence from the British Association of Social Workers, who wrote in after the oral sessions, conveying significant concerns about the Bill and stressing the absolute imperative of having proper family input at the right stage of the process. Indeed, the point seems to be half-recognised in the Bill, because clause 9 uses the phrase:

“in so far as the assessing doctor considers it appropriate”.

Again, doctors are being given that discretion not to proceed and to make sure that families are informed.

Requiring the doctor, when considering a patient's request for assistance to end their life, to decide whether it is appropriate to advise them to discuss it with their next of kin introduces several problems. It places a subjective burden on the doctor. The term “appropriate”

is very vague. Does it hinge on the patient's family dynamics, their emotional state or indeed the doctor's own biases?

Jake Richards (Rother Valley) (Lab): The amendment that the hon. Member is supporting speaks of a doctor having to consider what is

“in the person's best interests”,

which is wholly subjective. Does he not agree that the same difficulties he identifies with the current drafting are extrapolated greatly by the amendment?

Danny Kruger: I am afraid there is a huge degree of subjectivity throughout the Bill, and we are putting an enormous obligation on doctors to use their best judgment. However, I think it is right to stipulate more clearly that it is appropriate, in general, to inform patients' families. Leaving the vague term “appropriate” essentially implies that it is either/or—that it is a 50:50 choice whether they do so. So it is important to specify that the expectation is that they should do so. Of course, there will be circumstances in which that would not be the right thing to do, but as the amendments make clear, they should explain that clearly if they are not going to do so.

A doctor might hesitate to suggest a discussion with family if they suspect that there are strained relationships within it. My concern is that, without clear guidance, that judgment could be inconsistent or legally challenged. The doctor might know the next of kin and believe that they would try to stop the patient from ending their life. We have heard quite often the concern about the family being some sort of coercive force, trying to prevent people from fulfilling their autonomous choice to end their life, and that we should put in place barriers to stop families trying to dissuade their loved one from assisted suicide. We heard that repeatedly, particularly from the Australian witnesses.

My concern—this goes specifically to certain communities within our country—is that doctors from individualistic cultures, which we have in western Europe and North America, would prioritise personal autonomy. They would deem it inappropriate to suggest family involvement, viewing that as an intrusion on the patient's rights. We need to state clearly that that is not the expectation and that the expectation is that they should consider involving the family in the discussion.

My concern is also about an exaggerated respect for medical confidentiality. As the Committee knows, my belief is that this is not a healthcare treatment at all, but if it is to be regarded as such, we should not assume that medical confidentiality applies in an absolute sense. There are specific differences between this so-called medical treatment and others, which do justify an override of the assumption of total medical confidentiality. It is therefore appropriate, as in certain other medical procedures, that family members should be involved.

I want to cite the written evidence from Dr Rosemarie Anthony-Pillai, who pointed out that clause 9

“lays bare the reality that in trying to, rightly, diminish any accusation of coercion or family disagreement, this Bill will lead many to a lonely death.”

She also said:

“Families/loved ones finding out only after the event how the person died will have its own bereavement issues that this Bill in no way seeks to consider.”

I also cite the written evidence we had from *AtaLoss*, which is a UK charity dedicated to ensuring that bereaved people can access support. It said that discovering the decision that somebody has had help to take their own life without prior warning

“can replicate the distress often associated with sudden or suicide-related deaths, thereby intensifying bereavement trauma and potential suicide contagion.”

That is a very significant threat. We will not rehash the argument about whether suicide increases in countries with assisted suicide, but my strong view, from the evidence, is that it does.

In terms of the patient’s safety, if the process is kept secret even from those who know the patient well, the assessing doctors and the panel will be asking very difficult questions about the patient’s feelings and circumstances partly blindfolded. If a patient is in a controlling relationship, they and the person abusing them are not going to volunteer to the doctor or the panel that there is any pressure going on—indeed, the patient may not even understand it to be pressure. It is very common for an abusive partner to try to isolate the victim from their close friends and family. The hon. Member for Ealing Central and Acton (Dr Huq) wrote recently about how this has come up in her constituency. The ex-husband of her constituent’s sister reappeared on the scene, charmed and isolated this woman, and got her to change her will in his favour. That is a technique of coercive control. Some level of required notification to the wider family would make it much harder for a controlling partner to push someone through this process without it being exposed.

It was made clear earlier today that the Bill’s supporters do not want any hard-edged reasons that count as bad reasons to die to be stated in the Bill—they do not want it asked at all why someone wants to have an assisted death. As it stands, the doctors and the panel would have to approve the death as long as it was the patient’s clear, settled and informed wish, but involvement of those who know the patient well might demonstrate that it was not clear, settled or informed. They may have regularly gone through patches of feeling unloved and unsupported all their life, and that could change. That is information that only the wider family would know.

To conclude, there is real suffering hereto—as I have said, nobody exists in a vacuum. I want to reference the opinion of Judge Elósegui in the European Court of Human Rights. Her opinion was a partial dissent in the *Mortier* case, which has been discussed before. She said:

“it should be underlined that it cannot be said in an exhaustive way that the principle of autonomy always and at all costs has primacy over the other three principles of bioethics. In particular, we must take into account the consequences of our actions on the rest of the family unit and on our circle of friends.”

That is highly relevant. If we see cases where somebody dies by assisted suicide, and the first thing their child or parent knows about it is they are told to come and collect the body, that will be a scandal. That has happened in other countries, and the *Mortier* case is a case in point.

I mentioned other cases in which it is obligatory to consult and inform family members. At the moment, that is what happens at the Court of Protection with much less serious applications. Practice directive 9B requires doctors to notify

“at least three persons who are likely to have an interest in being notified”.

That is in the case of organ donation and other procedures. Families are required to be notified, and an indicative list is given, which is supposed to be worked through in order—spouses, people who live with as a spouse, parents, children and so on. The authorities are to jump along through that list, again with some discretion given to them.

To end, on the standard guidance referred to in judgments on that procedure, the judgement of Senior Judge Lush in the Court of Human Rights included the observation that the decision not to notify someone who would otherwise be entitled to be notified is not something that just affects the applicant. It is not just about their interests; there is a wider concern for the whole of society and indeed the family. That is why I support the amendment.

Dr Opher: I thank my hon. Friend the Member for York Central for tabling the amendment. The crucial word that the hon. Member for East Wiltshire said in all that was “should”. It is really important that people are strongly encouraged to discuss this with their families. Clause 9(2)(f) states that

“in so far as the assessing doctor considers it appropriate, advise the person to consider discussing the request with their next of kin and other persons they are close to.”

I totally support all that the hon. Member said: the family should always be involved in every decision. However, in the way we practice medicine in this country, if a patient has capacity—if they are not under a section under the Mental Health Act, for example, and can show that they have capacity—they can make decisions about their own healthcare. That involves whether they tell their family.

I agree that not to tell the family is not the best thing and not something I would say that the patient should do, but that is in their remit. It is important because, if we change that, we get rid of all the basis and the foundation of medical care and consent in this country. I agree wholeheartedly with the hon. Member, and I am a strong supporter of the family—I also think that in almost every situation the family will be involved—but the patient does not have to tell the family. That must remain part of their decision.

Daniel Francis (Bexleyheath and Crayford) (Lab): I am torn by this amendment. I absolutely accept that it is the right, the autonomy, of an individual to make the decisions and to have confidentiality when making those decisions, but I will touch on a few things that I have said previously.

First, briefly, I hear what the hon. Member for East Wiltshire said about coercion. Secondly, however, there are two other aspects. Let me go back to something I have talked long and hard about, which is learning disability. One amendment has been accepted and I hope more are to come, but given what my hon. Friend the Member for Stroud said, in that scenario, someone might have to be helped by the doctor to make the decision, because of their level of capacity. When I have made the argument throughout our debates, that has never ever been doubted. The person who has been helped to make that decision may have decided, because

[*Daniel Francis*]

they are a burden on their elderly parents, that they will not inform them. Again, that was the rationale of where I got to on Second Reading, frankly.

I see people with elderly parents, often now in their 70s or 80s, who have cared for that person throughout their life. As the Bill and the Mental Capacity Act are laid out, that person could go to the doctor to say, “I do not want my parents to know. I hear what you say, doctor, but under this provision of the Act”—clause 9 of the Bill—“I am not going to tell them.” Under the Mental Capacity Act, if the doctor had any queries about the capacity of that person to make those decisions, that doctor would have to assist them in making them. Let us be clear that that is what the Mental Capacity Act 2005 provides for, and that is what the code of practice says.

3.45 pm

I am sorry to keep talking about myself, but as I have said previously in these debates, during covid I was the carer for my whole household. My wife was having chemo and both my children were off school. One of my children needed full-time care, and no carers were allowed in the house. In that period, I really saw the power dynamic. I know exactly when it was: on the evening of Maundy Thursday, my wife had an enormous epileptic seizure during her chemotherapy treatment. I remember being on the phone to the cancer nurse who was saying, “Put her in an ambulance.” I said, “I’m not putting her in an ambulance because of covid.” I am sorry to be so graphic, folks, but that evening I had my wife in one bed covered in vomit and my daughter in one bed lying in her own faeces. The next morning, my wife would have done anything to remove me from that situation, quite frankly.

We were so lucky: a few months later, my wife’s chemo was finished and she was cancer free. We are out of that pandemic, thank goodness, but there are people out there who have had a loved one by their side for 30, 40, 50 or 60 years and do not want to see them go through that pain anymore. They will not take the decision out of fear; those who have six months left do not know what their end will be, and whether it will be painful or not. They just do not want the person who has stood by them all those years to have to be their carer. That is the power dynamic.

On balance, because I believe in autonomy, I may well not support the amendments, but these are the issues that I have wrestled with, because as the Bill stands, someone could simply go to a doctor, the doctor could say, “Have you told your loved one—your partner, your husband, your wife?” and they could say, “No, I’m not going to, because I do not want them to suffer anymore, caring for me in these circumstances.”

Danny Kruger: As ever, the hon. Gentleman speaks very powerfully. Does he acknowledge that under the amendments, and under the Bill, it would be possible for a patient to proceed without informing their wider family, if they and the doctor conclude that it is not appropriate or necessary? The value of the amendments is that they would require a conversation to be had about why that is not happening. Does the hon. Gentleman not recognise that such a conversation would be appropriate?

Daniel Francis: That is what I have wrestled with. That conversation will happen, and at the end of it, I accept that the autonomy is with the individual, who may well make a decision that they believe is for the best but with which their loved one does not necessarily agree. I think there are examples from overseas of that having happened.

Kit Malthouse (North West Hampshire) (Con): I agree about the primacy of autonomy, but does the hon. Gentleman agree that, given the status quo and the many stories that we have heard about individuals who took their lives but kept it secret from their families, whether by going to Switzerland or by doing it in a horrible way in lonely circumstances, a regulated atmosphere would make it more likely that people will talk to their family about what their death will be like and, as we have learned from overseas, make arrangements for their family to be around them, or at least to say goodbye, as they move into that process? At the moment, because this area is unregulated, way more people do it in secret than need to.

Daniel Francis: I am not entirely persuaded. I think there is currently a mixture of cases, and there will potentially be a mixture of cases in future. I hear what the right hon. Member says, but my primary concern is about the way things are. As I say, I am minded not to support the amendments on balance, but I am concerned that we could end up hearing stories about someone’s loved one of 50 years, or their child with a learning disability, having had an assisted death—and the first they knew about it was when it was too late.

Lewis Atkinson (Sunderland Central) (Lab): It is a pleasure to serve under your chairship this afternoon, Ms McVey.

I feel that we are dancing on the head of a pin, but I oppose the amendment. Members across the debate have recognised that, as Dr Sarah Cox from the Association for Palliative Medicine said, it is always for the patient to decide. As my hon. Friend the Member for Rother Valley pointed out, both the original clause and the amendment rightly retain that decision with the patient. They also retain the discretion of the doctor, whether that is on an appropriate test or a best interests test.

I note that in its submission the Royal College of Physicians advocated the removal of the clause, saying that it goes beyond current practice. I support the clause on balance, because of the importance of these conversations and so on, but the physicians who are likely to carry out the conversations think that it is inappropriate to specify these conversations in primary legislation.

There are two phrases in the amendment that I think are entirely inappropriate. First, there is “concluded in good faith”. I am sure it is not the intent of the author and mover of the amendment, but it suggests that in other instances people might be acting other than in good faith. I commend the words from my hon. Friend the Member for Ipswich. We have to start from the point that doctors are operating in good faith. It is dangerous to set up a good faith test, as opposed to an “other faith” test, in primary legislation.

Secondly, I am certainly not trying to reopen the long debates we had about the Mental Capacity Act, but Members will recall that in those debates we were very

clear that the “best interests” test should not and does not apply. Introducing language about best interests the first time in the Bill is very dangerous, and totally against the spirit and principle of what we have debated so far. For those reasons, I am against both amendments.

Jake Richards: My hon. Friend the Member for Sunderland Central has made many of the points that I planned to, so I will be brief. The primacy of patient autonomy when it comes to familial relationships is a principle that should not be interfered with in the medical sphere, which this is—we can call it treatment or something else, but it is undoubtedly a relationship between a doctor and a person.

I agree with my hon. Friend on the term “good faith”. I do not doubt the motives, but it put forwards the proposition that a doctor would act in bad faith and not tell a family member. It is a rather bizarre drafting, and wholly unhelpful for the intent for which it was put forward.

The most alarming is the second part and the issue of “best interests”. I will not labour the point that my hon. Friend has made, but what is a doctor to do? A doctor is not a social worker. A doctor is not a family support worker. What questions are they to ask? If someone says, “Oh, I don’t really want to tell my next of kin, who is my sister. We fell out last year because of tit for tat,” is the doctor going to make a value judgment as to whether that argument is profound enough to stop the notification?

Tom Gordon (Harrogate and Knaresborough) (LD): The point that the hon. Member makes is, I think, exactly the case—raising this conversation and talking about it is probably not in anyone’s best interests in the first instance. I think about my own situation. If I were to find myself terminally ill and falling within the scope of this law, and my mum had passed away, then my dad, who I have not spoken to in over a decade, with whom I have a very difficult and estranged relationship, would have to be notified and we would have to have a conversation about it. On my deathbed, the last thing I want to be thinking about is some childhood trauma being brought back before me in the confines of that terminal illness. Does the hon. Member agree that, while the intention might be good, the consequences could be damaging to the patient and their best interests?

Jake Richards: I agree. I think in some of these debates—I am probably guilty of this as well—we forget the context in which we are operating: someone is dying, imminently. Therefore, how we approach these conversations, these assessments and this process must take that into account.

Danny Kruger: The hon. Gentleman accurately points out that doctors are not social workers or psychiatrists, and we are asking them to make a difficult judgment, in consultation with the patient, about whether they should engage wider family in the discussion. That goes to the broader point: we are imposing a huge obligation on doctors to make very complicated decisions about capacity, coercion and the psychosocial circumstances of the patient. The value of this amendment’s saying, “I think we should involve the family if it is safe to do so”—it might very well not be in certain circumstances—is surely to assist them in having the wider conversation that is necessary.

Jake Richards: As we heard in evidence from the chief medical officer, doctors deal with capacity issues on a day-to-day basis; I am not sure they necessarily need assistance from family members in that regard. However, I appreciate the point—I was going to come to that—

Daniel Francis: Will my hon. Friend give way on that point?

Jake Richards: I am going to make some progress, because I am not sure that point is crucial to the debate about this amendment; I am sure my hon. Friend will grab me afterwards. I did not mean to mischaracterise the evidence on that point.

I accept that there is a tension here. No man is an island, as the hon. Member for East Wiltshire notes, and of course this process may cause upset to others. Equally, the input of third parties to the assessment of all the issues of eligibility is worth while, but it has to be dealt with in a proportionate way. When we debate clause 12—hopefully shortly—perhaps we can discuss that, and I hope to speak to that point.

However, this amendment is trying to crack that delicate nut with a huge hammer. It fundamentally changes the relationship between doctor and patient, and puts the doctor in a position where they do not have the skills or expertise to make that best interest decision. The amendment therefore fails, and that is why I will vote against it.

Rebecca Paul: I am concerned that maybe I am misunderstanding the debate. For clarity, right now clause 9 says that

“in so far as the assessing doctor considers it appropriate,” they should

“advise the person to consider discussing the request with their next of kin and other persons they are close to.”

It will read very similarly if the amendment is agreed to. Instead, it will say,

“unless the assessing doctor has concluded in good faith, that this would not be in the person’s best interests, advise the person to consider discussing the request with their next of kin and other persons they are close to”.

That is a very subtle change—it is just a little more encouragement to consider contacting the family. No one here is telling the doctor that they must tell the patient to contact the family; it is just a little bit of strengthening to encourage that. I invite the hon. Gentleman to confirm if I have misinterpreted, but that is my understanding of the clause.

Jake Richards: I will double check whether this is right, but the explanatory statement suggests that that is not the case. It says:

“This amendment would require the assessing doctor to inform the person’s next of kin that the person wishes to seek assistance to end their own life unless it is not in the person’s best interests.”

Rebecca Paul: That is not what it says.

Jake Richards: Even if that is not what it says, and even if the explanatory statement is wrong, it is not appropriate for doctors to advise patients what they should do with their family. Yes, they should consider it, but that is what this clause does. I will be voting against this amendment.

Stephen Kinnock: The amendments relate to whether the assessing doctor advises the person seeking assistance to end their own life to discuss that with their next of kin and other persons they are close to. Amendment 307 would change the test that the assessing doctor must apply before advising a person to consider doing so. The current test, as set out in clause 9(2)(f), is that “in so far as the assessing doctor considers it appropriate,” they must

“advise the person to consider discussing the request with their next of kin and other persons they are close to.”

The effect of amendment 307 is that the assessing doctor must advise the person to consider discussing their request with their next of kin and other persons they are close to, unless the assessing doctor has concluded in good faith that it would not be in the person’s best interests to do so. It should be noted that the amendment as drafted would not require the assessing doctor to inform the person’s next of kin, although there is some confusion, as that appears to be what is suggested by the explanatory statement.

Amendment 308 is consequential to amendment 307 and requires that

“If that doctor considers that it is not in the person’s best interests under paragraph (f), this decision and the doctor’s reasoning must be documented.”

I hope those observations were helpful.

4 pm

Kim Leadbeater: I have nothing to add, other than that I will not be supporting amendments 307 and 308. I associate myself with the comments made by my hon. Friends the Members for Rother Valley, for Stroud and for Sunderland Central.

Danny Kruger: I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Amendments made: 423, in clause 9, page 6, line 20, at end insert—

“(2A) To inform their assessment, the assessing doctor must—

- (a) consider whether they should consult a health professional or social care professional with qualifications in, or experience of, a matter relevant to the person being assessed;
- (b) consult such a professional if they consider that there is a need to do so.

(2B) Where an assessing doctor consults a professional under subsection (2A)(b), the assessing doctor must give a written record of the consultation to the other assessing doctor.”—(*Kim Leadbeater.*)

This amendment requires the assessing doctor to consider whether they should consult specialist health or social care professionals, and to consult them if they consider there is a need to do so. A record of any consultation must be shared with the other assessing doctor.

Amendment 415, in clause 9, page 6, line 20, at end insert—

“(2A) When making an assessment under subsection (2), the assessing doctor must first ensure the provision of adjustments for language and literacy barriers, including the use of interpreters.”—(*Jack Abbott.*)

Amendment 6, in clause 9, page 6, line 27, leave out “may” and insert “must”.—(*Sarah Olney.*)

This amendment would require the assessing doctor to refer the person being assessed for a mental capacity assessment if the assessing doctor had doubt as to the person’s capacity.

Amendment 370, in clause 9, page 6, line 29, leave out “registered in the specialism of psychiatry”

and insert

“a practising psychiatrist registered in one of the psychiatry specialisms”.

This is a drafting change.

Amendment 202, in clause 9, page 6, line 31, leave out “capability” and insert “capacity”.—(*Kim Leadbeater.*)

This amendment corrects a typographical error.

Clause 9, as amended, ordered to stand part of the Bill.

Clause 10

ANOTHER INDEPENDENT DOCTOR: SECOND OPINION

Amendments made: 203, in clause 10, page 6, line 42, at end insert—

“(A1) This section applies where the independent doctor has—

- (a) carried out the second assessment, and
- (b) made a report stating that they are not satisfied as to all of the matters mentioned in section 8(2)(a) to (e).”

This amendment is consequential on Amendment 421.

Amendment 204, in clause 10, page 6, line 43, leave out from beginning to second “the” in line 44.—(*Kim Leadbeater.*)

This amendment is consequential on Amendment 203.

Amendment proposed: 458, in clause 10, page 6, line 45, after “declaration” insert “and if there has been a material change of circumstances.”.—(*Sarah Olney.*)

Question put, That the amendment be made.

The Committee divided: Ayes 8, Noes 14.

Division No. 46]

AYES

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

NOES

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

Question accordingly negated.

Amendment made: 459, in clause 10, page 7, line 3, at end insert—

“(2A) “(a) Where a referral is made to a registered medical practitioner under subsection (1), the coordinating doctor must provide that new registered medical practitioner with the report by the independent doctor setting out their reasons for refusal.

(b) If the new registered medical practitioner reaches a different conclusion from the original independent doctor, they must produce a report setting out why they disagree.

(c) Those two reports must be made available to any subsequent decision maker under this Act and to the Commissioner.”—(*Sarah Olney.*)

Kim Leadbeater: I beg to move amendment 205, in clause 10, page 7, line 11, at end insert

“; but this is subject to subsection (4).

(4) Where—

(a) a referral is made under subsection (1) to a practitioner,

(b) the practitioner dies or through illness is unable or unwilling to act as the independent doctor, and

(c) no report under section 8 has been made by virtue of the referral,

a further referral may be made under subsection (1).”.

This amendment provides that a further referral may be made under this clause where a practitioner dies or is unable or unwilling to act as the independent doctor due to illness.

The Chair: With this it will be convenient to discuss clause stand part.

Kim Leadbeater: I will speak briefly to this small amendment, which provides that a further referral be made under clause 10 when a practitioner dies or is unable or unwilling to act as the independent doctor due to illness. In the very unlikely circumstances that the doctor who has agreed to give a second opinion dies or—because of illness or whatever reason—is unable to continue before making a report into the case, it would be right to seek a second opinion elsewhere. I hope the Committee will support my amendment 205.

Stephen Kinnock: This is one of the amendments on which the Government have worked with my hon. Friend the Member for Spen Valley to ensure that the Bill is legally robust and workable. As the Bill is currently drafted, in clause 11 there is provision to replace a registered medical practitioner acting as the co-ordinating doctor if they become ill or die. However, there is no similar provision to replace a registered medical practitioner acting as the independent doctor should they be unable to complete their role.

Amendment 205 makes provision under clause 10 that a further referral may be made by the co-ordinating doctor to another independent doctor if the second independent doctor becomes unable or unwilling to continue to make a report of their assessment due to their death or illness, provided that the second independent doctor has not prepared a report. It would thereby ensure internal consistency in the Bill in relation to this matter.

Sarah Olney (Richmond Park) (LD): I reiterate the concern I raised when speaking to my amendments this morning: as far as I can see, seeking the second opinion of a second independent doctor allows the person seeking assisted suicide to have a second bite at the cherry if their first independent doctor has not granted permission. I do not think anyone has an objection to going to a second independent doctor if the first independent doctor has been unable, through either death or illness, to complete the task; nor is there any objection if there has been a material change of circumstances, which my amendment 458 sought to add.

However, the possibility of seeking the view of another doctor simply because the first one did not give the desired answer is a troubling one. There is no objection to patients seeking a second, third or even fourth opinion in medicine when it is about what different treatment

pathways might be available, but there is a crucial difference between seeking different appropriate treatment options and what is being proposed in the Bill. In the Bill, the function of the two doctors is not primarily diagnostic or advisory; it is a safeguarding role.

The doctors will have been entrusted by Parliament to make sure that the criteria for assisted dying are met. Their determination makes the difference between a lawful act and the commission of an act that, as per clause 24, Parliament would still regard as sufficiently serious to be a crime. Their role is therefore that of a decision maker, and in no other setting can someone go to a different decision maker if they do not like the answer given by the first. Even in appeals before our courts, an appellate judge would not interfere with a decision simply because they would have reached a different conclusion; the appellate judge must consider that the decision was in some way incorrectly reached.

It is also true that in some settings one can ask a decision maker to reconsider a matter, but that is not what is being proposed in clause 10 either. Instead, the clause allows the person to try again with a different referee if the first one did not give the desired answer. It is true that there is an added layer of protection from the High Court or the possibility of a panel, but under the Bill as it currently is there is no procedure whereby the High Court or the panel will hear from the first independent doctor. That is concerning. They would have to go simply on the basis of the second independent doctor, without any awareness of why the two disagreed.

4.15 pm

Lewis Atkinson: I fear that the point the hon. Lady is making relates to before her amendment 459 was accepted. Does she not agree that by accepting amendment 459, we have guarded against the first independent assessment not being available for subsequent decision makers?

Sarah Olney: I am not used to my amendments being accepted. The hon. Gentleman is, of course, absolutely right.

Dr Matthew Doré, the palliative medicine consultant and honorary secretary of the Association for Palliative Medicine, said in written evidence:

“Allowing patients to seek multiple opinions undermines procedural integrity. Furthermore, allowing the coordinating doctor to seek multiple opinions even further undermines the selection of doctors willing to provide AD”—

that is, assisted dying. He goes on:

“The lack of a centralised tracking system facilitates ‘doctor shopping’.”

Notwithstanding the fact that amendment 459 has now been accepted, there is still grave concern about the possibility of doctor shopping. We should take steps to avoid it. That is why I am speaking against clause 10 in its entirety.

Under clause 8, the independent doctor has five matters to verify: that the person is terminally ill; that they have capacity; that they have a clear, settled and informed wish to end their own life; that they are acting voluntarily and without coercion or pressure; and they are over 18. The last requirement is unlikely ever to be in any form of doubt, so I will focus on the other four. The effect of clause 10 is to allow someone to be assisted to die when one out of three doctors who

[Sarah Olney]

examined them had concluded that they were not terminally ill, that they lacked capacity, that they did not have a settled wish to die or they were coerced. It therefore raises a real risk that someone not actually eligible for assisted dying would none the less be so assisted. In such matters of life and death, we ought to proceed with great caution.

Doctors can get things wrong, of course. If the first independent doctor did get it completely wrong, I would have no objection to the second independent doctor effectively acting as a form of appeal—or, to borrow the test from the law of medical negligence, if the first independent doctor reached a conclusion not supported by a reasonable body of medical opinion, of course it would be right for that opinion to be disregarded. But that is not what the Bill provides for, which is not an appeal or reconsideration but picking a new referee simply because the first answer was not desired.

I still have misgivings about clause 10 notwithstanding the fact that it has been amended. I urge other Committee members to vote against it. I appreciate your indulgence, Ms McVey.

Rebecca Paul: I rise to speak against clause 10 as it allows doctor shopping in the event that someone does not qualify for assisted dying. “Not happy with the verdict? Just find another doctor!” How many times are we happy for a patient to try again with a different doctor? It is inevitable that at some point the patient will find someone willing to make the statement and put them on their way to an assisted death, even if their eligibility is in doubt.

When I put forward the amendments tabled by my hon. Friend the Member for West Worcestershire (Dame Harriett Baldwin), which requested residual discretion for doctors, they were challenged by Committee members on the basis that the whole point of having defined criteria was so that they determined whether a patient was eligible. I run the same argument now: if the process is followed to the hilt and the independent doctor refuses to issue the statement, why on earth would we allow another bite—or even multiple further bites—at the cherry? Surely that is to allow abusers a way to push their victims into an assisted death by re-running the process again and again until they find a less attuned doctor.

Imagine the case of an elderly woman who has spent a lifetime under the coercive control of her husband. She is completely done with it all, and sees death as a welcome way to escape this man, who has made her life a misery. The abuse has escalated since she has become ill: because of her ill health, she cannot cook or clean any more, and he hates that. But no one sees. She never wanted the kids to know; she is really good at hiding it. Now, he wants to seek an assisted death, because it is better for them all. She agrees. When asked by a doctor, she is unlikely to say, “My husband is pressuring me into this, and I’m afraid of not doing what he wants,” particularly if she has suffered abuse over many years.

Let us say that the first independent doctor does a really thorough job—the kind of job that we hope all doctors would do. Perhaps the doctor manages to discern that the patient is very much controlled and unduly influenced by her husband. The trouble is that it can be

very difficult to find hard evidence of coercive control. According to recent figures, only 3.7% of recorded cases of controlling or coercive behaviour result in a charge, and more than half of cases are dropped because of evidential difficulties. The doctor therefore cannot get the police to intervene; his only lever is the power to reject the application. So that is what he does. But the patient does not give up; she is still absolutely sure that the best thing is an assisted death, and her abuser is still whispering in her ear, telling her she is right.

The second independent doctor does not have the same emotional intelligence as the first, and he does not see what the first doctor saw. He approves the application.

Lewis Atkinson: This is a similar point to the one I made before: amendment 459, which we have just passed, means that, in the scenario that the hon. Lady describes, the second independent doctor will have in their possession the first independent doctor’s concerns about coercion. Does she not agree?

Rebecca Paul: I will come to that exact point shortly.

Members of the Committee will recall that I previously tried to get “undue influence” and “encouragement” added to the Bill explicitly to deal with more subtle forms of influence and pressure, as opposed to those that are more obvious to third parties. When objecting to my amendments, the Minister said that they were unnecessary, because “coercion or pressure” already covered them. I hope that the Minister is proven to be correct.

The key point is that those forms of behaviour are not always easily discernible. Dr Mullock told us in oral evidence that

“the kind of undue influence that might occur might be very subtle. More needs to be done to recognise that and the subtle encouragement that might take place, where a relative might frame their support for the person seeking to die in terms of, ‘This will be better for you,’ and, ‘Have you considered this?’ That is not necessarily an example of clear abuse, so when the person seeking to die then consults the doctor, they are not going to characterise what has happened to them as coercion or abuse. More needs to be done to discuss with the person whether or not they have been encouraged by the people around them.”—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 29 January 2025; c. 162, Q204.]

These are the very real consequences of this clause, which undermines the independent doctor safeguard. In written evidence, Mr Michael Vidal hits the nail on the head:

“It seems to negate the purpose of having a second opinion if the second opinion can be ignored and a fresh second opinion obtained.”

I recognise and welcome the fact that amendment 459 has been accepted. It would mean that the second independent doctor would have the benefit of the report of the first independent doctor. However, this is not a failsafe protection and cannot be relied on entirely. First, the report of the first independent doctor is required to be made available to the patient. In a case such as this, would the first doctor want to spell out exactly what led to that conclusion, knowing that it could place the patient in harm’s way if her husband saw it? Also, he is not 100% sure; does he want to make such accusations in writing without hard evidence?

Secondly, even if the report was detailed and available to the second independent doctor, he would still need to make his own assessment, and he might not agree. Or it

could be that although he recognises signs of coercion over a long period, he may truly believe that, to the best of his knowledge, the decision made by the patient has not been coerced in that moment.

I am afraid therefore that clause 10 is a loophole that will be exploited by domestic abusers, and it is largely women who will pay the price. For that reason, I cannot support it.

Lewis Atkinson: I was not going to speak to this clause, but I feel I must rebut some of the points made, which are clearly incorrect. The hon. Member for Reigate asks how many further opinions there will be; the answer is clearly one, because that is what is set out in the Bill. The safeguards in amendment 459 mean that it is not just the second doctor who will be aware of the first doctor's concerns; any subsequent decision maker will be.

We are about to discuss significant amendments in clause 12. However, whether there is a panel or the decision remains with a High Court judge, it is inconceivable that, when presented with an initial assessment that the criteria are not met and a subsequent assessment that disagrees with it, that third-tier decision maker will not want to explore the issues in detail. I believe that all Committee members are trying to work together in a spirit of genuinely improving the legislation, but our arguments and discussions need to reflect the amendments that we have accepted. Clause 10, as amended, is significantly improved and strengthened. It continues to provide significant safeguards for the Bill, and I am happy to support it.

Amendment 205 agreed to.

Question put, That the clause, as amended, stand part of the Bill.

The Committee divided: Ayes 19, Noes 3.

Division No. 47]

AYES

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

NOES

Kruger, Danny	Paul, Rebecca
Olney, Sarah	

Question accordingly agreed to.

Clause 10, as amended, ordered to stand part of the Bill.

Clause 11

REPLACING THE COORDINATING DOCTOR ON DEATH ETC

Sarah Olney (Richmond Park) (LD): I beg to move amendment 461, in clause 11, page 7, line 15, leave out “or otherwise”.

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

Amendment 310, in clause 11, page 7, line 23, at end insert

“and

- (c) to ensure the High Court is notified of the substitution of the coordinating doctor and the reason for the substitution.”

This amendment would include ensuring the High Court is notified of substitutions of the coordinating doctor in the list of matters the Secretary of State may by regulations make provision for.

Amendment 309, in clause 11, page 7, line 23, at end insert—

- “(3) Regulations under subsection (1) must include provision to require the reassessment of the patient under section 7.”

This amendment would require a regulations covering the replacement of the coordinating doctor to include a reassessment of the person by the new coordinating doctor.

Clause stand part.

Sarah Olney: The amendment would remove the phrase “or otherwise” in the clause. All I am proposing is for the wording to be consistent with amendment 205 to clause 10, which has just been agreed. It does not specify “or otherwise”, but simply uses the words, “the practitioner dies or through illness is unable or unwilling”.

What might “otherwise” incorporate? It indicates that there might be a range of reasons beyond death or illness why the co-ordinating doctor would drop out. In many ways, I am trying to probe what the other reasons might be. If there are no other reasons, and consistent with amendment 205 that we have just agreed, we should drop the phrase “or otherwise”.

4.30 pm

Danny Kruger: I want to speak briefly in support of the hon. Lady's amendment and also in support of amendment 310, tabled by the hon. Member for York Central. The hon. Member for Richmond Park is absolutely right. I will not rehearse her argument, which is very straightforward. The question is: what other reason could there be to justify a co-ordinating doctor transferring the case? The Committee might reject that amendment, in which case I hope they will accept the amendment tabled by the hon. Member for York Central, which specifies that whatever the reason, particularly if it is other than death or illness, it is important for the High Court or the panel to be notified of the substitution and the reason why.

Sarah Green (Chesham and Amersham) (LD): Maternity leave is one reason and retirement might be another.

Danny Kruger: Those might be appropriate reasons; I hope that can be specified. The crucial thing is that if there is an unwillingness—not an incapacity but an unwillingness—to proceed, that is of some concern. It is not that they are no longer able to do it—possibly for the reasons that the hon. Lady suggested—but if there is an actual unwillingness to proceed, what is the reason?

On amendment 309, if the first doctor is replaced for whatever reason, surely it is imperative that the new doctor conduct their own assessment, rather than taking the previous doctor's word for it. A doctor is legally

[*Danny Kruger*]

responsible, obliged under all medical regulation and law for their actions, and they cannot rely on a previous assessment. If the first doctor gave up the case because of some kind of incapacity—an illness, or, indeed, their demise—it might be that their own judgment was impaired at the time. I would have thought it was obvious that the new doctor should take responsibility for conducting an assessment and proceeding with full responsibility for the case.

Naz Shah: I rise to speak to amendment 309 tabled by my hon. Friend the Member for York Central. The amendment proposes that if a doctor changes, there should be a reassessment of the patient. My understanding is that that is in line with current practice: if a doctor is changed, the new doctor has to assess a patient to their own satisfaction because they cannot rely on just looking at notes. It is a sensitive issue where a doctor is required to make objective and subjective assessments, as has been agreed by the Committee to date, in clinical decision making. A clinician does not inherit the risk of another clinician without being satisfied themselves that the conclusion of another clinician aligns with their own.

For instance, the clinician has a responsibility to fulfil their own professional standards and their own duty of care. In the light of the significant impact of the decision, it is important that the doctor can be satisfied as they will need to consent to a patient having capacity and not being coerced. They cannot just take the word of another clinician who has managed the case before them. They themselves need to be satisfied. If a doctor does not do that and something goes wrong, and it comes to light that the patient did not have capacity, the clinician who is the new co-ordinating doctor would carry liability. It does not stand up if they say, “But someone else assessed that the patient had capacity” or, “Someone else said that the patient had not been coerced” if it comes to light later that they have.

This measure would therefore protect the clinician and ensure that the patient understood that a further assessment would need to take place. Having this measure in law would hopefully dissuade doctors from transferring their patients unless absolutely necessary for the continuity of care. It would also dissuade the clinician from taking on a new case if they were aware that continuity of care would be disrupted, due to, for example, a move.

Stephen Kinnock: This set of amendments relates to the Secretary of State’s ability to make provision, by regulations, for the replacement of the co-ordinating doctor if they are unable to continue to carry out the functions of the co-ordinating doctor.

I will turn first to amendment 461. Clause 11, as currently drafted, provides the Secretary of State with a discretionary power to make regulations that provide for cases

“where, after a first declaration has been witnessed by the coordinating doctor, that doctor dies or through illness or otherwise is unable or unwilling to continue”.

Amendment 461 removes the “or otherwise”. The effect could be to limit scenarios in which the Secretary of State could make provision via regulations for the replacement of the co-ordinating doctor. The Secretary of State could not provide for replacing the co-ordinating doctor in circumstances other than a doctor’s death or

illness, which could include family issues or retirement. That would mean that the person seeking an assisted death may need to begin the process again.

Amendment 310 expands the list of matters that regulations made under subsection (1) may cover. That includes notifying the High Court of substitutions of the co-ordinating doctor, where the co-ordinating doctor is unable to continue to carry out their functions. It should be noted that clause 11 confers only a power, not a duty, on the Secretary of State to make regulations about replacing the co-ordinating doctor. It is not certain that the matter of a substitution of the doctor would be covered in those regulations.

The explanatory statement for amendment 309 suggests that the amendment aims to ensure that a replacement co-ordinating doctor is required to carry out a new assessment of the patient—in other words, to repeat the first assessment made under clause 7. The amendment requires that the regulations that may be made by the Secretary of State under subsection (1) make provision for such cases. Although the Secretary of State has a power to make regulations to provide that the co-ordinating doctor be replaced by another doctor, that is not a requirement. The amendment assumes that there will be a replacement co-ordinating doctor, which is not a specific requirement of the legislation.

Kim Leadbeater: I will speak briefly about amendment 461. A co-ordinating doctor is central to the whole process set out in the Bill, from start to finish. If a co-ordinating doctor becomes unavailable, a replacement would need to be found. There may be a number of reasons, not restricted to the doctor’s own death or illness, why that could happen. We have already heard a few examples—it could be retirement, maternity leave or anything going on in that doctor’s personal life. A close family member might fall ill or die, or something else might happen in the doctor’s life that forces them to withdraw. We have talked a lot about patient autonomy, quite rightly, but we need to think about the autonomy of the doctors involved in the process as well. It is therefore important that they have the ability to step away, as set out in clause 11. Additionally, I associate myself with the Minister’s comments about amendments 309 and 310. It feels as though those amendments do not necessarily do what was intended.

Sarah Olney: I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Amendment made: 206, in clause 11, page 7, line 24, leave out subsection (3).—(*Kim Leadbeater.*)

See the statement for Amendment 188.

Clause 11, as amended, ordered to stand part of the Bill.

4.41 pm

Sitting suspended.

5 pm

On resuming—

[*CAROLYN HARRIS in the Chair*]

Clause 12

COURT APPROVAL

Daniel Francis: I beg to move amendment 105, in clause 12, page 8, line 15, leave out subsections (4) and (5) and insert—

“(4A) Rules of Court must secure that in relation to an application under subsection (1), the High Court must—

- (a) prescribe a procedure which in relation to each application appoints a person (the Official Solicitor in cases in brought in England and Wales) to act as advocate to the Court,
- (b) hear from and question, in person—
 - (i) the person who made the application for the declaration,
 - (ii) the coordinating doctor,
 - (iii) the independent doctor, and
- (c) consider hearing from and questioning, in person—
 - (i) persons properly interested in the welfare of the person who made the application for the declaration and other persons they are close to, and
 - (ii) any other person who has provided treatment or care for the person being assessed in relation to that person’s terminal illness.”

This amendment would require court rules to be made that would ensure an adversarial court process, by appointing an advocate to the court. It would also require them to hear from the person seeking assistance to end their life and both assessing doctors, and to consider also hearing from family members and others involved in the person’s care.

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

Amendment 407, in clause 12, page 8, line 19, leave out “may” and insert “must”.

This amendment would require the High Court to hear from and question the person who made the application for the declaration.

Amendment 410, in clause 12, page 8, line 27, leave out subsection (6).

The amendment would remove the ability of the court to hear from and question any person other than the person who made the application for the declaration and the assessing doctors.

Amendment 106, in clause 12, page 8, line 30, leave out “(5)” and insert “(4A)”.

This amendment is consequential on Amendment 105.

Amendment 107, in clause 12, page 8, line 44, leave out “(4)” and insert “(4A)”.

This amendment is consequential on Amendment 105.

Daniel Francis: I will withdraw amendment 105 later, but will speak to it briefly, as my name is on it. The amendment aims to require court rules to be made that would ensure an adversarial court process, by appointing an advocate to the court. It would also require them to hear from the person seeking assistance to end their life and both assessing doctors, and to consider also hearing from family members and others involved in the person’s care.

In our oral evidence sessions, we heard from Nicholas Mostyn and Alex Ruck Keene about some of the merits of doing so, with reference to the Bill that was before us at that stage. Since then, a significant number of amendments and new clauses have been tabled, so I will not press this amendment to a vote, given the other amendments now before the Committee.

Juliet Campbell: I rise to speak to amendments 407 and 410. Amendment 407 would leave out the word “may” and insert the word “must”, and would require the High Court to hear from and question all persons who made the application for a declaration. It is a

probing amendment, which aims to question the guidelines for the judge to question and hear from some people and not all people. I will not press the amendment to a vote, but I seek clarity on what the criteria would be for the judge to question some people and not others.

Kim Leadbeater: I hope I can provide some reassurance. This issue is covered by my new clause 21. The amendment, I think, asks why the High Court would not have heard from the patient. My new clause would ensure that the panel—as it potentially would be—will hear from the patient.

Juliet Campbell: I thank my hon. Friend for that explanation.

I move on to amendment 410, which would remove the ability of the court to hear from and question any person other than the person who made the application or the declaration for an assisted death and the assessing doctors. I have strong reservations about using a proxy or giving another person the right to speak on behalf of an individual who wishes to have an assisted death, and I question the scope of those people who could be the proxy to speak on behalf of a person requesting an assisted death. Who exactly would those people be?

One of the arguments we have consistently debated in this Committee is around coercion and patient autonomy. When multiple third parties such as family members or caregivers are allowed to testify, there is an increased risk that an individual might influence the court’s decision in a way that is not aligned to the true wishes of the applicant. In some cases we have talked about pressure from family members or loved ones, for whatever reason—whether their vested interest is financial or something else—to have the applicant hasten their death or have an assisted death. I would not want that kind of pressure to be put on the person and I do not believe any third party should be allowed to speak on their behalf or to be a proxy.

By limiting the scope of the testimony to the applicant and assessing doctors only, the amendment helps to safeguard against such manipulative tactics and ensures that the court focuses solely on the applicant’s own will and the medical assessment of their eligibility, removing the potential for family dynamics or any other outside influence to interfere with the judicial review. It offers a necessary refinement to the Bill for assisted deaths, a request that is both efficient and respectful of the autonomy of all people involved. By limiting the court testimony to the applicant and assessing doctor, the amendment addresses several of the concerns I have spoken about.

Jake Richards: I will speak briefly, because many of these issues and themes will be debated in clause stand part and amendments 371 and the others from my hon. Friend the Member for Spen Valley. Amendment 267 was not moved, but I would have opposed it in any event, on the basis that the discretion given there was way too wide and I did not understand the basis of the amendment in any way. Amendments 105 to 107, tabled my hon. Friend the Member for Derby North (Catherine Atkinson), attempt to add an adversarial element to proceedings. Again, I will not comment too much because that issue comes back in the fourth grouping under this clause.

[*Jake Richards*]

I turn briefly to amendment 410, to which my hon. Friend the Member for Broxtowe just spoke. My understanding is that, although this relates to the High Court—which may be deemed redundant as we move on through this clause—the amendment aims to limit the people that the judge or panel can hear from. In my view that would be wrong and dangerous. The purpose of a judge or a panel is to explore the circumstances in this matter. That must mean that they have discretion to hear from others as well. In my view, this amendment, if passed, would significantly limit the safeguards and be quite dangerous.

As my hon. Friend has already said, amendment 407 has been superseded, and I think we all agree on that.

The Minister of State, Ministry of Justice (Sarah Sackman): It is a pleasure to serve under your chairship, Mrs Harris. As I and my colleague and hon. Friend the Member for Aberfan Maesteg have made clear throughout the debate, the Government continue to remain neutral on this Bill and do not take a position on assisted dying. My remarks will therefore focus on the legal and practical impact of the amendments, to assist the members of this Committee in undertaking line-by-line scrutiny.

Amendments 267 and 105 to 107, which have now been withdrawn, deal with the Bill as currently drafted in relation to the High Court. Clause 12 as currently drafted would require the High Court to make a declaration that the requirements of the Bill have been met, following a person's first declaration to receive assistance to end their own life, with statements from a co-ordinating doctor and an independent doctor. The amendments relate to how the High Court will declare itself satisfied that a person has a clear, settled and informed wish to end their own life and that they have not been coerced or pressured.

Briefly, amendments 407 and 410 seek to change who the High Court—as others have said, we might come on to debate some of these themes relation to the panel—would engage with when considering applications for assistance under the Bill. In determining whether the person has a clear, settled, and informed wish to end their life and that they have not been coerced or pressured, the High Court would be required to hear from and question the person seeking assistance, as opposed to having the option to do so. As my hon. Friend the Member for Spen Valley pointed out, in the later provision in relation to the panel, that has now become a requirement.

As my hon. Friend the Member for Broxtowe made clear, under her amendment 410 the High Court would lose the ability to hear from or indeed question any other party other than the person seeking assistance and the assessing doctors. Removing the ability—whether of the High Court or, as we may come on to debate, of the panel—to hear from and question any other party may limit that body or court's ability to interrogate wider evidence or points of view.

Juliet Campbell: The probe that I have on that point is that the individual who is seeking the assisted death, and the doctors who have been working with that person, really have all the information. I am trying to

ascertain, if we are not going to agree on this amendment, who else they would be seeking information from. Is there a risk if they are getting evidence from family members or other people, or having them give evidence or speak on behalf of that declaration?

Sarah Sackman: As I understand it, both in the context of the High Court—which has the ability to speak to whomever it likes—and of the panel, when we come to debate its role, that is a discretion. It is a requirement to hear from the person seeking an assisted death; it is a requirement to hear from the co-ordinating doctor. However, hearing from others is discretionary, which means that, if it is necessary in order to be satisfied that the eligibility criteria are met—which is what the scheme requires—in that context, under the panel's or the High Court's discretion, it may seek evidence from elsewhere. That is what the provision, as the Government reads it, is designed to do.

The amendment that my hon. Friend the Member for Broxtowe puts forward clearly limits that discretion; whether that is desirable is a policy choice, but that is how it is intended to function. As I have said, the Government will continue to remain neutral on these substantive policy questions, but I hope that is useful to members of the Committee.

Kim Leadbeater: I think I have responded to the hon. Member for Broxtowe on amendment 407 by saying that the concern will potentially be covered by my new clause 21. On amendment 410, it is also my view that, whether it is the High Court or the panel or whoever we end up having over the course of this Committee, that third layer of scrutiny and safeguarding should be able to hear from other people, not just the patient and the doctor, so I would not support that amendment.

Daniel Francis: I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Amendment proposed: 410, in clause 12, page 8, line 27, leave out subsection (6).—(*Juliet Campbell.*)

The amendment would remove the ability of the court to hear from and question any person other than the person who made the application for the declaration and the assessing doctors.

Question put, That the amendment be made.

The Committee divided: Ayes 2, Noes 21.

Division No. 48]

AYES

Campbell, Juliet

Francis, Daniel

NOES

Abbott, Jack

Olney, Sarah

Atkinson, Lewis

Opher, Dr Simon

Charalambous, Bambos

Paul, Rebecca

Gordon, Tom

Richards, Jake

Green, Sarah

Sackman, Sarah

Hopkins, Rachel

Saville Roberts, rh Liz

Joseph, Sojan

Shah, Naz

Kinnock, Stephen

Shastri-Hurst, Dr Neil

Kinnoch, Danny

Tidball, Dr Marie

Leadbeater, Kim

Woodcock, Sean

Malthouse, rh Kit

Question accordingly negatived.

5.15 pm

Danny Kruger: I beg to move amendment 432, in clause 12, page 8, line 31, leave out paragraph (a).

This amendment is linked to amendments which remove proxies from the Bill.

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

Amendment 433, in clause 19, page 13, line 26, leave out subsection (4).

This amendment is linked to amendments which remove proxies from the Bill.

Amendment 434, in clause 36, page 22, line 16, leave out paragraph (c).

This amendment is linked to amendments which remove proxies from the Bill.

Danny Kruger: I recognise that we are moving on and that we want to get on to the substantive clauses, and I certainly will not press these amendments to a vote. However, I want to put on record that I have extreme concerns about the role of the proxy in clause 15. It is unclear to me why a proxy is needed. I regret that we are not sticking with the High Court process, which would have enabled us to debate these amendments at this stage, but I will let it pass.

Sarah Sackman: Amendments 432 to 434 would remove provisions regarding proxies from the Bill. They deal with proxies in the context of the High Court process. As a consequence, the High Court would be unable to hear from the person's proxy where the proxy has signed the first declaration, and the person would be unable to use a proxy to authorise a medical practitioner to provide assistance to end their own life. Removing the ability for persons seeking assistance to use a proxy would limit access to the assisted dying process for people who, for example, have a physical impairment, are unable to read or are for some other reason unable to sign the declaration. As I said earlier, the Government remain neutral, but I hope that provides some context and an explanation of how the amendments would operate.

Kim Leadbeater: I will be brief, because we will come on to this debate when we get to clause 15. To be clear, the circumstances where a proxy would be involved in this process are literally when somebody is so ill that they are unable to sign their own name, so it is a very limited set of circumstances.

Danny Kruger: I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Danny Kruger: I beg to move amendment 312, in clause 12, page 8, line 34, at end insert—

“(7A) Any person who wishes to challenge an application for a declaration under subsection (1) must enter a caveat in any district registry of the High Court within 14 days of the application being lodged or received, stating their belief that the requirements of this Act have not been met in relation to the first declaration, with specific reference to the matters listed in subsection (3).

(7B) Where a caveat is entered under subsection (7A), the High Court must hear from the person who has entered the caveat in addition to those persons listed in subsections (5) and (6).”.

This amendment would allow a person who believes that the requirements of the Act have not been met to make this known to the High Court and be heard before a declaration is made.

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

Amendment 269, in clause 12, page 8, line 35, leave out subsections (8) to (11) and insert—

“(8) Any party to the proceedings may apply for permission to appeal to the Court of Appeal in accordance with the applicable Rules of Court.”.

This amendment would allow any party to apply for permission to appeal a decision and remove the requirement for the Court of Appeal to conduct a re-hearing.

Amendment 313, in clause 12, page 9, line 1, leave out subsection (11).

This amendment would enable appeals to be heard against a decision by the High Court to make a declaration.

Danny Kruger: Again, I will not press this amendment; I just want to put on record my support for the principle. This amendment, tabled by the hon. Member for York Central, is quite a clever device: if we were sticking with the High Court, it would have meant that someone with genuine concerns, for example a family member or acquaintance of a patient, could flag them without needing to be informed that the application was going ahead.

As we have discussed, there is a concern about these proceedings happening in the dark, as it were, without wider family being informed. If a family member suspected that there might be an assisted dying application in the works and that they were being excluded from consideration or discussion of that, there would have been the opportunity to put on record their concern, which would have required the judge to take a wider consideration than would be enabled without this amendment. I regret that that is not happening, but it may be possible through the course of the Bill to ensure that there will be further opportunities to introduce such measures. I welcome that new clause 21 would impose a requirement on the panel to consider family members, so there is an element of the right system there.

Sarah Sackman: Amendments 312 and 313 would make several changes to the process for High Court approval of applications under the Bill as drafted. Amendment 312 would allow a person who believes that the requirements of the Act have not been met to make that known to the High Court and to be heard before a declaration is made. The proposed mechanism is that the person would enter a caveat in any district registry of the High Court within 14 days of the application being lodged or received.

Of course we will come to later amendments, but under the Bill as drafted, the High Court has the power to hear from and question any person to determine whether the applicant has a clear, settled and informed wish to end their own life, and that they have not been pressured or coerced, so there is that mechanism to hear from others through that channel.

Amendment 313 would enable appeals to be made against a decision by the High Court to make a declaration, as opposed to only where a declaration is not granted. As drafted, the Bill provides that any person may seek a judicial review of any decision of the High Court, including the decision to make a declaration, if they are adjudged to have standing.

Amendment 269 would enable any person, other than the person seeking assistance, to apply for permission to appeal to the Court of Appeal against a decision of

[Sarah Sackman]

the High Court. The amendment would also enable appeals to be made against a decision by the High Court to grant a declaration, as opposed to only where a declaration is not granted. The Court of Appeal would not be obliged to consider the matters set out in the Bill when forming its decision. It is important to say that whether with or without the amendment, any person may still seek a judicial review of any decision of the High Court, if they are adjudged to have standing.

Kim Leadbeater: I have nothing to add.

Danny Kruger: I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Question proposed, That the clause stand part of the Bill.

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

Amendment 371, in clause 13, page 9, line 5, leave out paragraph (a) and insert—

“(a) a certificate of eligibility has been granted in respect of a person, and”.

This amendment is consequential on NC21.

Amendment 61, in clause 13, page 9, line 5, leave out from “the” to “has” and insert “First-tier Tribunal”.

This amendment is consequential on NC2 and NC3.

Amendment 372, in clause 13, page 9, line 12, leave out from third “the” to end of line 13 and insert “certificate of eligibility was granted.”.

This amendment is consequential on NC21.

Amendment 62, in clause 13, page 9, line 13, leave out from “the” to “or” in line 14 and insert “First-tier Tribunal”.

This amendment is consequential on NC2 and NC3.

Amendment 373, in clause 13, page 9, line 17, leave out “declaration was made” and insert “certificate was granted”.

This amendment is consequential on NC21.

Amendment 377, in clause 16, page 11, line 12, leave out paragraph (d) and insert—

“(d) a certificate of eligibility has been granted in respect of a person;

(da) a panel has refused to grant such a certificate;”.

This amendment is consequential on NC21.

Amendment 63, in clause 16, page 11, line 12, leave out “the” to “has” and insert “First-tier Tribunal”.

This amendment is consequential on NC2 and NC3.

Amendment 378, in clause 18, page 12, line 9, leave out paragraph (a) and insert—

“(a) a certificate of eligibility has been granted in respect of a person,”.

This amendment is consequential on NC21.

Amendment 64, in clause 18, page 12, line 9, leave out from “the” to “has” and insert “First-tier Tribunal”.

This amendment is consequential on NC2 and NC3.

Amendment 381, in clause 27, page 16, line 16, leave out sub-paragraph (iii) and insert—

“(iii) a certificate of eligibility,”.

This amendment is consequential on NC21.

Amendment 65, in clause 27, page 16, line 16, leave out from “the” to “under” and insert “First-tier Tribunal”.

This amendment is consequential on NC2 and NC3.

Amendment 388, in clause 34, page 20, line 40, leave out paragraph (c) and insert—

“(c) a panel has refused to grant a certificate of eligibility;”.

This amendment is consequential on NC21.

Amendment 66, in clause 34, page 20, line 40, leave out from “the” to “has” and insert “First-tier Tribunal”.

This amendment is consequential on NC2 and NC3.

Amendment 390, in clause 40, page 23, line 24, at end insert—

“‘certificate of eligibility’ has the same meaning as in section (Determination by panel of eligibility for assistance);”.

This amendment is consequential on NC21.

Amendment 391, in clause 40, page 23, line 24, at end insert—

“‘the Commissioner’ has the meaning given by section (Voluntary Assisted Dying Commissioner);”.

This amendment is consequential on NC14.

New clause 14—*Voluntary Assisted Dying Commissioner*—

“(1) There is to be a Voluntary Assisted Dying Commissioner.

(2) The Commissioner is to be appointed by the Prime Minister.

(3) The person appointed must hold or have held office as a judge of—

- (a) the Supreme Court,
- (b) the Court of Appeal, or
- (c) the High Court.

(4) The Commissioner’s principal functions are—

- (a) receiving documents made under this Act;
- (b) making appointments to a list of persons eligible to sit on Assisted Dying Review Panels (see Schedule (Assisted Dying Review Panels));
- (c) making arrangements in relation to such panels and referring cases to them (see section (Referral by Commissioner of case to multidisciplinary panel));
- (d) determining applications for reconsideration of panel decisions under section (Reconsideration of panel decisions refusing certificate of eligibility);
- (e) monitoring the operation of this Act and reporting annually on it (see section 34).

(5) In this Act “the Commissioner” means the Voluntary Assisted Dying Commissioner.

(6) Schedule (The Voluntary Assisted Dying Commissioner) makes provision about the Commissioner.”.

This new clause provides for there to be a Voluntary Assisted Dying Commissioner.

New clause 15—*Referral by Commissioner of case to multidisciplinary panel*—

“(1) This section applies where the Commissioner receives—

- (a) a first declaration made by a person,
- (b) a report about the first assessment of the person which contains a statement indicating that the coordinating doctor is satisfied as to all of the matters mentioned in section 7(2)(a) to (g), and
- (c) a report about the second assessment of the person which contains a statement indicating that the independent doctor is satisfied as to all of the matters mentioned in section 8(2)(a) to (e).

(2) The Commissioner must, as soon as reasonably practicable, refer the person’s case to an Assisted Dying Review Panel for determination of the person’s eligibility to be provided with assistance under section 18.

(3) But where the Commissioner receives a notification that the first declaration has been cancelled—

- (a) the Commissioner must not refer the person's case to such a panel, and
- (b) if the person's case has already been so referred, the Commissioner must notify the panel of the cancellation.

(4) Schedule (Assisted Dying Review Panels) makes provision about Assisted Dying Review Panels.”

This new clause provides for the Voluntary Assisted Dying Commissioner to refer a person's case to a multidisciplinary panel, to be called an Assisted Dying Review Panel.

New clause 17—Reconsideration of panel decisions refusing certificate of eligibility—

“(1) This section applies where—

- (a) a person's case is referred under section (Referral by Commissioner of case to multidisciplinary panel) to an Assisted Dying Review Panel (“the first panel”), and
- (b) the first panel refuses to grant a certificate of eligibility in respect of the person.

(2) The person may apply to the Commissioner for their case to be reconsidered on the ground that the first panel's decision—

- (a) contains an error of law,
- (b) is irrational, or
- (c) is procedurally unfair.

(3) The Commissioner must consider an application without a hearing.

(4) On the application—

- (a) if the Commissioner is satisfied that any of the grounds mentioned in subsection (2) applies, they must as soon as reasonably practicable refer the person's case to a different Assisted Dying Review Panel for a fresh determination under section (Determination by panel of eligibility for assistance);
- (b) in any other case, the Commissioner must dismiss the application.

(5) The Commissioner must give reasons, in writing, for their decision.

(6) The Commissioner must notify the following of the outcome of the application, and give them a document containing their reasons for their decision—

- (a) the person who made the application;
- (b) the coordinating doctor;
- (c) any other person specified in regulations made by the Secretary of State.”

This new clause provides for certain decisions of Assisted Dying Review Panels to be referred to a different panel for reconsideration.

Amendment (a) to new clause 17, leave out subsections (1) to (3) and insert—

- “(1) The person applying for assisted dying, their next of kin, any of their relatives (within the meaning of the Family Law Act 1996), the registered medical practitioners who are treating them and anyone who took part in proceedings before the panel or gave evidence to the panel may apply to the Commissioner for the Panel's decision to be reconsidered.
- (2) The Commissioner will allow the application for reconsideration if the Panel's decision was—
- (a) wrong, or
 - (b) unjust because of a serious procedural or other irregularity in the proceedings.
- (3) The Commissioner may consider the application without a hearing if they consider it in the interests of justice to dispense with a hearing.”

New clause 21—Determination by panel of eligibility for assistance—

“(1) This section applies where a person's case is referred under section (Referral by Commissioner of case to multidisciplinary panel) or (Reconsideration of panel decisions refusing certificate of eligibility) to an Assisted Dying Review Panel (“the panel”).

(2) The panel's function is to determine whether it is satisfied of all of the following matters—

- (a) that the requirements of sections 5 to 9 have been met in relation to—
 - (i) the first declaration,
 - (ii) the first assessment and the report under section 7 on that assessment, and
 - (iii) the second assessment and the report under section 8 on that assessment;
- (b) that the person is terminally ill;
- (c) that the person has capacity to make the decision to end their own life;
- (d) that the person was aged 18 or over at the time the first declaration was made;
- (e) that before making the first declaration, but when the person was aged 18 or over, a registered medical practitioner conducted a preliminary discussion with the person;
- (f) that the person is ordinarily resident in England and Wales and has been so resident for at least 12 months ending with the date of the first declaration;
- (g) that the person is registered as a patient with a general medical practice in England or Wales;
- (h) that the person has a clear, settled and informed wish to end their own life;
- (i) that the person made the first declaration voluntarily and was not coerced or pressured by any other person into making that declaration.

(3) Subject to the following and to Schedule (Assisted Dying Review Panels), the panel may adopt such procedure as it considers appropriate for the case.

(4) The panel—

- (a) must hear from, and may question, the coordinating doctor or the independent doctor (and may hear from and question both);
- (b) must (subject to subsection (5)) hear from, and may question, the person to whom the referral relates;
- (c) in a case to which section 15 applies, may hear from and may question the person's proxy;
- (d) may hear from and may question any other person;
- (e) may ask any person appearing to it to have relevant knowledge or experience to report to it on such matters relating to the person to whom the referral relates as it considers appropriate.

In paragraphs (a) to (c) the reference to hearing from or questioning a person is to hearing from them, or questioning them, in person or by live video or audio link.

(5) The duty under subsection (4)(b) to hear from the person to whom the referral relates does not apply if the panel is of the opinion that there are exceptional circumstances which justify not hearing from that person.

(6) The panel—

- (a) must, if it is satisfied of all of the matters mentioned in subsection (2), grant a certificate to that effect (a “certificate of eligibility”);
- (b) must refuse to do so in any other case.

(7) The panel must notify the following of its decision—

- (a) the person to whom the referral relates;
- (b) the coordinating doctor;
- (c) the Commissioner;
- (d) any other person specified in regulations made by the Secretary of State.

Where it grants a certificate of eligibility, it must give a copy of the certificate to each of these persons.

(8) If the panel is notified that the first declaration has been cancelled, it must cease to act in relation to the referral (and, in particular, it may not grant a certificate of eligibility).”

This new clause provides for a person's eligibility to be provided with assistance under clause 18 to be determined by a multidisciplinary panel (instead of the High Court).

Amendment (d) to new clause 21, in subsection (4), leave out paragraphs (a) to (e) and insert—

- “(a) must hear from, and must question, the coordinating doctor and the independent doctor;
- (b) must (subject to subsection (5)) hear from, and must question, the person to whom the referral relates;
- (c) in a case to which section 15 applies, must hear from and must question the person’s proxy;
- (d) must consider hearing from and questioning—
 - (i) persons properly interested in the welfare of the person who made the application for the declaration and other persons they are close to; and
 - (ii) any other person who has provided treatment or care for the person being assessed in relation to that person’s terminal illness; and
- (e) may hear from and may question any other person, including any person appearing to it to have relevant knowledge or experience to report to it on such matters relating to the person to whom the referral relates as it considers appropriate.”

Amendment (c) to new clause 21, in subsection (4), after paragraph (e) insert—

- “(aa) if it considers that the matters mentioned in subsection 2(c), (h) or (i) are established on a balance of probabilities but still considers that there is a real risk that they are not satisfied, then the panel must stay its proceedings until such further inquiries it orders are made.”.

Amendment (e) to new clause 21, after subsection (4) insert—

“(4A) Where the panel considers it appropriate for medical reasons, it may make provision for the use of pre-recorded audio or video material for the purposes of subsection (4).”

Amendment (a) to new clause 21, in subsection (6)(a), after “satisfied” insert “beyond reasonable doubt”.

Amendment (b) to new clause 21, in subsection (6)(a), after “subsection (2)” insert

“unless it believes that there are particular circumstances which make it inappropriate for the person to be assisted to end their own life.”.

New clause 2—Tribunal authorisation—

“(1) Where—

- (a) a person has made a first declaration under section 5 which has not been cancelled,
 - (b) the coordinating doctor has made the statement mentioned in section 7(3), and
 - (c) the independent doctor has made the statement mentioned in section 8(5), that person may apply to the First-tier Tribunal (“the Tribunal”) for a declaration that the requirements of this Act have been met in relation to the first declaration.
- (2) On an application under this section, the Tribunal—
- (a) must make the declaration if it is satisfied of all the matters listed in subsection (3), and
 - (b) in any other case, must refuse to make the declaration.
- (3) The matters referred to in subsection (2)(a) are that—
- (a) the requirements of sections 5 to 9 of this Act have been met in relation to the person who made the application,
 - (b) the person is terminally ill,
 - (c) the person has capacity to make the decision to end their own life,
 - (d) the person has relevant and available palliative care options available to them,
 - (e) the person is not liable to be detained under the Mental Health Act 1983,
 - (f) the person was aged 18 or over at the time the first declaration was made,

- (g) the person is ordinarily resident in England and Wales and has been so resident for at least 12 months ending with the date of the first declaration,
- (h) the person is registered as a patient with a general medical practice in England or Wales,
- (i) the person has a clear, settled and informed wish to end their own life, and
- (j) the person made the first declaration and the application under this section voluntarily and has not been coerced or pressured by any other person into making that declaration or application.

(4) The Tribunal—

- (a) may hear from and question, in person, the person who made the application for the declaration;
- (b) must hear from and may question, in person, the coordinating doctor or the independent doctor (or both);
- (c) for the purposes of paragraph (b), may require the coordinating doctor or the independent doctor (or both) to appear before the tribunal.

(5) For the purposes of determining whether it is satisfied of the matters mentioned in subsection (3)(g) and (h), the Tribunal may also—

- (a) hear from and question any other person;
- (b) ask a person to report to the Tribunal on such matters relating to the person who has applied for the declaration as it considers appropriate.

(6) In considering an application under this section, the panel must consist of—

- (a) a sitting judge,
- (b) a medical practitioner, and
- (c) a lay person.

(7) In subsection (4)—

- (a) in paragraph (a), the reference to the person who made the application includes, in a case where the person’s first declaration was signed by a proxy under section 15, that proxy, and
- (b) “in person” includes by means of a live video link or a live audio link.”

This new clause would replace the role of the High Court with the tribunal system.

New clause 3—Tribunals in Wales—

“(1) For the purposes of this Act, the First-tier Tribunal and the Upper Tribunal, in exercising functions under or arising from this Act in relation to Wales, are to be treated as devolved tribunals within the meaning of paragraph 9 of Schedule 7A to the Government of Wales Act 2006.

(2) The Welsh Ministers may by regulations make provision relating to the procedure to be followed by the First-tier Tribunal and the Upper Tribunal in exercising functions under this Act in relation to Wales.

(3) Statutory instruments containing regulations made under this section may not be made unless a draft of the instrument has been laid before and approved by resolution of Senedd Cymru.”

Amendment 67, in schedule 4, page 28, line 32, leave out from “The” to “has” and insert “First-tier Tribunal”.

This amendment is consequential on NC2 and NC3.

Amendment 68, in schedule 5, page 30, line 6, leave out from “the” to “made” and insert “First-tier Tribunal”.

This amendment is consequential on NC2 and NC3.

Amendment 69, in schedule 5, page 30, line 10, leave out from “the” to end of line and insert “First-tier Tribunal”.

This amendment is consequential on NC2 and NC3.

Amendment 70, in schedule 6, page 32, line 3, leave out from “of” to “declaration” and insert “First-tier Tribunal”.

This amendment is consequential on NC2 and NC3.

New schedule 1—*The Voluntary Assisted Dying Commissioner*—

“Status

- 1 (1) The Commissioner is to be a corporation sole.
- (2) The Commissioner is not to be regarded as—
 - (a) the servant or agent of the Crown, or
 - (b) as enjoying any status, immunity or privilege of the Crown.
- (3) The Commissioner’s property is not to be regarded as property of, or property held on behalf of, the Crown.

General powers

2 The Commissioner may do anything the Commissioner considers appropriate for the purposes of, or in connection with, the Commissioner’s functions.

Deputy Commissioner

3 (1) The Prime Minister must appoint a person to be the Deputy Voluntary Assisted Dying Commissioner (the “Deputy Commissioner”).

(2) The person appointed must hold or have held office as a judge of—

- (a) the Supreme Court,
- (b) the Court of Appeal, or
- (c) the High Court.

(3) The Commissioner may delegate any of the Commissioner’s functions to the Deputy Commissioner, to the extent and on the terms that the Commissioner determines.

(4) The delegation of a function under sub-paragraph (3) does not prevent the Commissioner from exercising that function.

(5) The functions of the Commissioner are to be carried out by the Deputy Commissioner if—

- (a) there is a vacancy in the office of the Commissioner, or
- (b) the Commissioner is for any reason unable or unwilling to act.

Appointment and tenure of office

4 (1) A person holds and vacates office as the Commissioner or Deputy Commissioner in accordance with the terms and conditions of their appointment as determined by the Secretary of State, subject to the provisions of this paragraph.

(2) An appointment as the Commissioner or Deputy Commissioner is to be for a term not exceeding five years.

(3) A person may not be appointed as the Commissioner or Deputy Commissioner if a relevant appointment of them has been made on two occasions. “Relevant appointment” here means appointment as the Commissioner or Deputy Commissioner.

(4) The Commissioner or Deputy Commissioner may resign by giving written notice to the Secretary of State.

(5) The Secretary of State may by notice in writing remove a person from the office of Commissioner or Deputy Commissioner if satisfied that the person—

- (a) has behaved in a way that is not compatible with their continuing in office, or
- (b) is unfit, unable or unwilling to properly discharge their functions.

Remuneration

5 The Secretary of State may pay to, or in respect of, the person holding office as the Commissioner or Deputy Commissioner—

- (a) remuneration;
- (b) allowances;
- (c) sums by way of or in respect of pensions.

Staff: appointed by Commissioner

6 (1) The Commissioner may appoint staff.

(2) Staff are to be appointed on terms and conditions determined by the Commissioner.

(3) The terms and conditions on which a member of staff is appointed may provide for the Commissioner to pay to or in respect of the member of staff—

- (a) remuneration;
- (b) allowances;
- (c) sums by way of or in respect of pensions.

(4) In making appointments under this paragraph, the Commissioner must have regard to the principle of selection on merit on the basis of fair and open competition.

(5) The Employers’ Liability (Compulsory Insurance) Act 1969 does not require insurance to be effected by the Commissioner.

Staff: secondment to Commissioner

7 (1) The Commissioner may make arrangements for persons to be seconded to the Commissioner to serve as members of the Commissioner’s staff.

(2) The arrangements may include provision for payments by the Commissioner to the person with whom the arrangements are made or directly to seconded staff (or both).

(3) A period of secondment to the Commissioner does not affect the continuity of a person’s employment with the employer from whose service he or she is seconded.

Staff: general

8 (1) Before appointing staff under paragraph 6 or making arrangements under paragraph 7(1), the Commissioner must obtain the approval of the Secretary of State as to the Commissioner’s policies on—

- (a) the number of staff to be appointed or seconded;
- (b) payments to be made to or in respect of staff;
- (c) the terms and conditions on which staff are to be appointed or seconded.

(2) A function of the Commissioner may be carried out by any of the Commissioner’s staff to the extent authorised by the Commissioner (but this is subject to sub-paragraph (3)).

(3) Sub-paragraph (2) does not apply in respect of—

- (a) the Commissioner’s function under paragraph 2(1) of Schedule (Assisted Dying Review Panels) of making appointments to the list of persons eligible to be panel members;
- (b) the Commissioner’s function of determining applications for reconsideration under section (Reconsideration of panel decisions refusing certificate of eligibility).

Financial and other assistance from the Secretary of State

9 (1) The Secretary of State may—

- (a) make payments to the Commissioner of such amounts as the Secretary of State considers appropriate;
- (b) give such financial assistance to the Commissioner as the Secretary of State considers appropriate.

(2) The Secretary of State may—

- (a) provide staff in accordance with arrangements made by the Secretary of State and the Commissioner under paragraph 7;
- (b) provide premises, facilities or other assistance to the Commissioner.

Accounts

10 (1) The Commissioner must—

- (a) keep proper accounts and proper records in relation to them, and
- (b) prepare a statement of accounts in respect of each financial year in the form specified by the Secretary of State.

(2) The Commissioner must send a copy of each statement of accounts to the Secretary of State and the Comptroller and Auditor General—

- (a) before the end of August next following the end of the financial year to which the statement relates, or
- (b) on or before such earlier date after the end of that year

as the Treasury may direct.

(3) The Comptroller and Auditor General must—

- (a) examine, certify and report on the statement of accounts, and
- (b) send a copy of the certified statement and the report to the Secretary of State.

(4) The Secretary of State must lay before Parliament each document received under sub-paragraph (3)(b).

(5) In this paragraph, “financial year” means—

- (a) the period beginning with the date on which the Commissioner is established and ending with the second 31 March following that date, and
- (b) each successive period of 12 months.

Application of seal and proof of documents

11 (1) The application of the Commissioner’s seal is to be authenticated by the signature of—

- (a) the Commissioner, or
- (b) a person who has been authorised by the Commissioner for that purpose (whether generally or specially).

(2) A document purporting to be duly executed under the Commissioner’s seal or signed on the Commissioner’s behalf —

- (a) is to be received in evidence, and
- (b) is to be treated as duly executed or signed in that way, unless the contrary is shown.

Public Records Act 1958

12 In Part 2 of the Table in paragraph 3 of the First Schedule to the Public Records Act 1958 (bodies whose records are public records), at the appropriate place insert “The Voluntary Assisted Dying Commissioner”.

House of Commons Disqualification Act 1975

13 In Part 3 of Schedule 1 to the House of Commons Disqualification Act 1975 (offices disqualifying person from membership of House of Commons), at the appropriate place insert—

“The Voluntary Assisted Dying Commissioner or the Deputy Voluntary Assisted Dying Commissioner.”

Freedom of Information Act 2000

14 In Part 6 of Schedule 1 to the Freedom of Information Act 2000 (public authorities for the purposes of the Act) , at the appropriate place insert—

“The Voluntary Assisted Dying Commissioner.”

Equality Act 2010

15 In Part 1 of Schedule 19 to the Equality Act 2010 (public authorities subject to public sector equality duty), at the end of the group of entries for bodies whose functions relate to health, social care and social security insert—

“The Voluntary Assisted Dying Commissioner.””

This new Schedule contains provision about the Voluntary Assisted Dying Commissioner and the Deputy Commissioner.

New schedule 2—Assisted Dying Review Panels—

“Introduction

1 In this Schedule—

- (a) “referral” means a referral under section (Referral by Commissioner of case to multidisciplinary panel) or (Reconsideration of panel decisions refusing certificate of eligibility) (and similar references are to be construed accordingly);
- (b) “panel” means an Assisted Dying Review Panel.

List of persons eligible to be panel members

2 (1) The Commissioner must make appointments to a list of persons eligible to sit as members of panels.

(2) A person may be appointed to the list only if—

- (a) the person (a “legal member”)—
 - (i) holds or has held high judicial office,
 - (ii) is one of His Majesty’s Counsel, or

(iii) has (at any time) been requested to act as a judge of the Court of Appeal or the High Court by virtue of section 9(1) of the Senior Courts Act 1981,

(b) the person (a “psychiatrist member”) is—

- (i) a registered medical practitioner,
- (ii) a practising psychiatrist, and
- (iii) registered in one of the psychiatry specialisms in the Specialist Register kept by the General Medical Council, or

(c) the person is registered as a social worker in a register maintained by Social Work England or Social Work Wales (a “social worker member”).

(3) In this paragraph “high judicial office” means office as—

- (a) a judge of the Supreme Court,
- (b) a judge of the Court of Appeal, or
- (c) a judge or deputy judge of the High Court.

Tenure of persons appointed to list

3 (1) Subject to the provisions of this paragraph, persons on the list hold and vacate their appointments in accordance with the terms on which they are appointed.

(2) An appointment to the list is to be for a period not exceeding five years.

(3) A person who has held appointment to the list is eligible for re-appointment for one further period not exceeding five years.

Membership of panels

4 (1) The Commissioner must make arrangements for determining the membership of a panel.

(2) The arrangements must ensure that a panel consists of—

- (a) a legal member,
- (b) a psychiatrist member, and
- (c) a social worker member.

Decisions of panels

5 (1) The legal member of a panel is to act as its chair.

(2) Decisions of a panel may be taken by a majority vote; but this is subject to sub-paragraph (3).

(3) The panel is to be treated as having decided to refuse to grant a certificate of eligibility if any member votes against a decision to grant such a certificate.

Panel sittings

6 (1) Panels are to determine referrals in public (but this is subject to sub-paragraph (2)).

(2) The chair of a panel may, at the request of the person to whom a referral relates, decide that the panel is to sit in private.

Staff and facilities

7 The Commissioner may make staff and other facilities available to panels.

Practice and procedure

8 (1) The Commissioner may give guidance about the practice and procedure of panels.

(2) Panels must have regard to any such guidance in the exercise of their functions.

Reasons

9 Panels must give reasons, in writing, for their decisions.

Money

10 The Commissioner may pay to or in respect of members of panels—

- (a) remuneration;
- (b) allowances;
- (c) sums by way of or in respect of pensions.

House of Commons Disqualification Act 1975

11 In Part 3 of Schedule 1 to the House of Commons Disqualification Act 1975 (offices disqualifying persons from membership of House of Commons), at the appropriate place insert—

“Person on the list of those eligible for membership of an Assisted Dying Review Panel.””

This new Schedule contains provision about Assisted Dying Review Panels.

Amendment (c) to new schedule 2, in paragraph 4, after

“(c) a social worker member.”

insert—

“(3) The Commissioner must ensure that each member of a panel has had training in respect of domestic abuse, including coercive control and financial abuse.”

Amendment (a) to new schedule 2, in paragraph 4, after

“(c) a social worker member.”

insert—

“(3) Each member of a panel must have fluent proficiency in the Welsh language if services or functions in the Act are to be provided to an individual in Welsh.”

Amendment (b) to new schedule 2, in paragraph 8, leave out sub-paragraphs (1) and (2) and insert—

“(1) The Commissioner must give guidance about the practice and procedure of panels.

(2) Such guidance must prescribe a procedure which in relation to each application appoints a person nominated by the Official Solicitor to act as advocate to the panel.

(3) Panels must have regard to such guidance in the exercise of their functions.”

This amendment would require Assisted Dying Panels to follow an adversarial process to test the evidence by appointing an advocate to the panel.

Danny Kruger: Could you just repeat that? [*Laughter.*]

Kim Leadbeater: I hope you are sitting comfortably, Mrs Harris; it is a pleasure to see you this evening. I rise to speak to new schedules 1 and 2, new clauses 14, 15, 17 and 21, and their consequential amendments. These provisions relate to the introduction of the assisted dying commission, which would oversee the assisted dying process in England and Wales, and the multi-disciplinary panels of experts, which will operate as part of the commission, should the Bill be passed.

It has always been my view, and I have always been clear, that there should be a third layer of scrutiny and safeguarding in the assisted dying process, particularly given the significance of the change in the law. However, I appreciate that, if we compare the Bill with the many other models of assisted dying around the world, this is very unusual. Most jurisdictions have a process that involves two doctors, as the Bill does, but there is no additional stage.

There are different views as to whether a third layer is necessary; many other jurisdictions have processes that provide a very compassionate, patient-centred and well-safeguarded approach to assisted dying without it. Indeed, some of the most difficult emails I receive are from terminally ill people who are very concerned about the complexity of the process laid out in the Bill. They feel that it is overcomplicated and too bureaucratic to navigate for people who are in their dying days and weeks. I am very sensitive to that. I am also aware that the thorough process set out in the Bill will take time, and there will be people who embark upon it who will die before they can complete it, as happens in other jurisdictions. That is, of course, extremely sad.

I also know that, certainly in this country, people feel strongly that oversight and scrutiny of what we might call the initial medical stages of the assisted dying process are important. The challenge is achieving an appropriate balance between compassion and patient autonomy, and robust safeguarding—plus, of course, medical autonomy.

If there is to be a third layer, what should it look like? As the Bill stands, the third layer of scrutiny is a High Court judge, who would make the final decision regarding a patient’s choice to have an assisted death. I was, and remain, very confident in the ability of High Court judges to have that role, but it is fair to say that there is a range of views on the suitability of the judiciary to fulfil this function—not least from ex-judges themselves. It is important that we as a Committee acknowledge that.

Barrister and former Supreme Court judge Lord Sumption said that

“clause 12 is unnecessary and in some respects undesirable.”

He went on:

“The concern that I have about clause 12 in its current form is that it is not entirely clear what the judge is supposed to do... is he there in order to ensure that the two doctors have done their job and that the ducks are all in a row, or is he there to form his own view on all of those matters, completely independently of those who have already given their certificates?... It seems to me that this is a protection that no other country, so far as I am aware, among those that have authorised one or other form of assisted dying has included.”—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 29 January 2025; c. 172-173, Q222.]

Lord Sumption has been critical of the complexity of the process set out in the Bill as drafted, describing it as “over-engineered, bureaucratic, and coldly inhumane”.

He told us in evidence that he disagreed with the inclusion of the need for High Court approval of a person’s application for an assisted death.

Former High Court judge Sir James Munby has written various articles in this regard. In his piece “Assisted dying: what role for the judge?” he asks:

“Should the judges be involved at all in this process? Is what is proposed a proper judicial function?”

He continues:

“Is this, indeed, truly a judicial function at all? Many would say that it is not. Where else in our judicial system does one find a judge, sitting judicially as a judge, whose function is not to decide some disputed issue or... to resolve some controversy but only to certify, as it were, that some decision taken by a private individual complies with the law? That, it might be said, is not what judges do and not what judges are for.”

He also expresses his concerns around conscientious objection and the challenges of ensuring

“an open and transparent process that may deter those for whom the scheme is designed, and a secret process destructive of the integrity of the scheme and corrosive of the judicial function.”

I absolutely agree that this is a very tricky balance.

Danny Kruger: The hon. Lady cites James Munby, who correctly identified the problems with the High Court process as it was designed and exists in the Bill. Is she aware that he also strongly objects to the amendments? He thinks that the newly proposed scheme fails on all the same tests, and he regards it as just as unsafe as the previous one.

Kim Leadbeater: The hon. Gentleman makes a good point. It is fair to say that there is a range of views on this subject from the judiciary. Ex-judges have commented, and I will come to those comments shortly.

[Kim Leadbeater]

In his evidence, the chief medical officer, Professor Sir Chris Whitty, said that the best safeguards were the simple ones and warned that patients could find themselves in “a bureaucratic thicket” at the end of life if there is too much to navigate. I am very sensitive to that. Responding to his comments, Lord Sumption said:

“I do agree with that...one suggestion that I think would make a significant difference...is the removal of the clause 12 stage.”—*[Official Report, Terminally Ill Adults (End of Life) Public Bill Committee, 28 January 2025; c. 182, Q236.]*

That shows the difference of opinion among former judges.

5.30 pm

Another former High Court judge, Sir Nicholas Mostyn, when discussing assisted dying on his podcast “Movers and Shakers”, expressed strong opposition to the involvement of the High Court bench in the process. He argued that the judge would be

“no more than a symbolic rubber stamp.”

I would argue that point, and that was certainly not my intention when I drafted the Bill. Of course, checking that the process has been followed is very important, but it would be pointless if the third layer were undertaking a purely administrative role. I agree with Sir Nicholas that it would be disastrous if the judge were to be seen as no more than a rubber stamp, hence the inclusion of the obligation for the judge to hear from at least one of the medical practitioners—it could be both—as well as the option to hear from the patient and anybody else they wish.

In their letter to MPs, the former Law Officers said they shared Sir James Munby’s concerns that the Bill fails to align with the purpose and integrity of the judiciary, saying:

“This Bill would place judges in an unprecedented role—not to resolve disputes, but merely to certify that an individual’s decision to end their life complies with the law. Such a function fundamentally conflicts with judicial principles, undermining the judiciary’s very purpose.”

However, Sir James also says:

“I am not contending that there can never be any role for the judge in the context of assisted dying. My concern was (and is) as to the *function of the judge* and the *nature of the process* envisaged under the scheme proposed in the Bill”.

I am very respectful of these different views, but my view remains that a third layer of safeguarding and scrutiny is very important. Former Clerk of the House of Commons David Natzler, who was Parliament’s most senior legal and constitutional adviser, asked:

“the question surely is, how CAN confidence be given about the status of an applicant’s expressed and witnessed wish? What non-judicial regime, while having to be swift and not onerously expensive for the applicant or the public, would satisfy, for example, a retired President of the Family Division?”

That is the question I have reflected on at great length since Second Reading.

I have listened carefully to the commentaries and the evidence, and I have taken the decision to introduce the assisted dying commission, detailed in new schedule 1, which would oversee all applications and assign all patients who request an assisted death to a multidisciplinary panel of experts, as per new schedule 2. The panels would be chaired by a “legal member”, who

“holds or has held high judicial office...is one of His Majesty’s Counsel, or...has (at any time) been requested to act as a judge of the Court of Appeal or the High Court”.

They would sit alongside a psychiatrist and a social worker. That multidisciplinary approach would maintain the valuable skills, legal expertise and judicial oversight in the Bill as drafted, with a judge or retired judge acting as the commissioner plus a legal chair of each panel. It would also address the concerns about the role of the judge acting alone in a traditional judicial capacity, without removing the important third layer of scrutiny and safeguarding. Very importantly, it would add multidisciplinary expertise relating to the two biggest issues we have spoken about so much in this debate: assessing capacity and checking for coercion.

As we have already discussed at great length in the Committee, there was a huge amount of evidence about the benefits of a multidisciplinary approach to choice at the end of life. As such, I have already proposed changes to the Bill that would ensure that is the case. My amendment 423 to clause 9 requires both assessing doctors to consider consulting health and social care professionals, and to consult such professionals whenever they consider that there is a need to do so, and a record of any consultation must be shared with the other assessing doctor. The amendment imposes a specific duty on the assessing doctors to consider whether any other expert input is required. I am pleased that the amendment was supported by the Committee.

We have also discussed amendment 6 tabled by the hon. Member for St Albans (Daisy Cooper), which I support and I think the Committee will support. It would provide that when either doctor has any doubt about the capacity of the patient, they must refer them to a psychiatrist. Importantly, as I have said repeatedly and we must remember, nothing in the Bill replaces or precludes the multidisciplinary approach witnesses have told us about, which already takes place when treating and caring for terminally ill patients.

However, to really embed and emphasise this comprehensive, multidisciplinary approach, new schedules 1 and 2 provide details of the assisted dying commissioner and the assisted dying review panels, which I hope colleagues can support. There is a huge amount of support for this approach. In an open letter last weekend, three former Directors of Public Prosecutions—Dame Alison Saunders, Sir Max Hill and Lord Ken Macdonald—as well as a former Lord Chancellor and Secretary of State for Justice, and many eminent legal professionals and academics, wrote in support of the introduction of the assisted dying commission and specialist panels. They stated:

“We believe this makes the Bill the strongest and safest of its kind in the world, and a marked improvement on the status quo in this country, which fails to offer meaningful upfront protections...The proposal of an assisted dying commission represents an important step”

towards

“bringing end-of-life decisions out of the shadows and greatly increasing the support and protection available for terminally ill people”.

As the former DPPs have said, the existing law is not fit for purpose. Loved ones who help a terminally ill person end their life could face up to 14 years in prison. Dame Alison, who was DPP from 2013 to 2018, said that she was moved to tears when advising on her first

case of assisted dying, and that it was “ghastly” for families to be hauled before police after losing a loved one. Lord Macdonald said that the law is a “real mess” and “discriminatory” against those who cannot afford to travel to Switzerland, and that

“prosecutors are making law by deciding there’s a category of case they won’t prosecute. In the meantime, a lot of people are suffering very ugly deaths. So I think the whole situation is just grim at the moment.”

I agree with him, and they all agree with the

“proposal of multidisciplinary panels, each chaired by a judge or KC, assisted by the expertise of psychiatrists and social workers,” saying that it is “sensible and practical”. They are approving of the role of retired judges, who they note are

“frequently deployed on to public inquiries or as highly skilled mediators”.

Glyn Berry, co-chair of the Association of Palliative Care Social Workers, told us in oral evidence:

“As social workers, our expertise and strength is in being able to ask difficult questions and really dig into people’s thoughts, feelings and opinions”.

She said that having worked

“in a hospice setting for the last six or seven years...I see daily how social workers contribute to the wider MD team in terms of safeguarding, capacity and applications for deprivation of liberty, but we also do the psychosocial aspect of palliative and end-of-life care...Having conversations about people wishing to end their life is not a new thing: we have those conversations quite regularly.”

She added:

“We have...an extensive skills catalogue...one of our biggest skills we have is in communication and in not being afraid to go where other professionals may feel uncomfortable”—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 28 January 2025; c. 53-54, Q58.]

Glyn Berry also said that

“we feel...that the role of an approved palliative care professional would sit beside the role of clinicians, balancing clinical and social observation and assessment.”—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 28 January 2025; c. 56, Q66.]

I agree, and I think their inclusion in the panels is a real strengthening of the Bill.

Claire Williams, head of pharmacovigilance and regulatory services at NorthWest EHealth and chair of the Greater Manchester central research ethics committee, told us in her oral evidence:

“I absolutely agree that a panel/committee approach would have better safeguarding for patients, because the decision is being made collectively with legal expertise and with other healthcare professionals...It is having that collective view, ensuring that everybody is happy and that that is exactly what the patient wants. I believe it should be a committee/panel-based approach for the final decision.”—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 30 January 2025; c. 244, Q314.]

Even Alex Ruck Keene, for whom I have a huge amount of respect, but who I think it is fair to say is not a supporter of a change in the law, said:

“The more people we have who are able to bring their different perspectives—the social work perspective on the person’s social circumstances or the medical perspective on their medical condition—the better, so that we have as many eyes on the person and insights into the person as possible.”—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 28 January 2025; c. 91, Q121.]

As I have said, most jurisdictions do not have a third layer of scrutiny, but there is evidence that an inquisitorial and investigative layer works. Retired High Court judge Sir Nicholas Mostyn spoke about how assisted dying works in Spain, which I believe is the only other jurisdiction where a panel of some description is involved. There,

“the chairperson of the regulator sets up a panel for each case—a doctor and a lawyer. They have to agree and they check that everything has been done lawfully.”

He added:

“Interestingly, in 2023, 10% extra denials were done by the panel...so the panel was not just rubber-stamping.”—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 28 January 2025; c. 88, Q115.]

I think that is really important, and I know colleagues will be reassured by it.

Danny Kruger: I have made this point before, but I will do so again: it is very welcome to have these extra professionals involved in the process. Does the hon. Lady not recognise that it would be so much more appropriate to have them involved early on, at the assessment stage? We all want it not to be just a rubber stamp, but they are currently to be involved at the approval stage, at the end of the process, essentially fulfilling a judicial function of deciding yes or no. Why are these professionals not involved earlier?

Kim Leadbeater: I disagree: they are involved earlier. I have talked about the amendments we have already made around health and social care professionals. We have tabled those amendments, changed the Bill and added that provision on the basis of the evidence we heard. Remember that either doctor can speak to any other health or social care professional they wish. I would say that, actually, a multidisciplinary approach is taken throughout the Bill and, by ending the process with the panel, that is reinforced.

The hon. Member for East Wiltshire said in his radio interview on 12 February, “I do welcome”—as he has confirmed today—“the additional role of more experts in the process”. Hopefully, irrespective of our different views, that is something that the idea of the panel can coalesce around. Despite the hon. Gentleman’s opposition to assisted dying, I hope that, in the interests of strengthening the Bill, he will be able to support the amendments today, because that is the job of this Committee—to strengthen the Bill, not to try to stop it, however strongly people may feel about the issue.

A significant part of the strengthening is through additional patient-centred safeguards. I firmly believe that the introduction of the assisted dying commission and the addition of the multidisciplinary expertise and oversight provided by the panels are a crucial part of that. The panel will look at the detail of every individual case and scrutinise the doctors’ reports. It must hear from and may question the co-ordinating doctor or the independent doctor; it may hear from and question both; and it must hear from and may question the patient themselves. I mentioned that in relation to the amendment from my hon. Friend the Member for Broxtowe earlier. It is the default.

This was a difficult decision. I appreciate that to make the patient undergo another level of personal scrutiny could be viewed as cruel. Indeed, a number of

[*Kim Leadbeater*]

people have said to me that they feel it will be too burdensome on the patient during what is already a deeply emotional, highly personal and stressful time, when they are likely to be in pain and having treatment. I acknowledge that. Again, this is about finding the very difficult balance between avoiding an unduly stressful bureaucratic process and ensuring that the patient is making, as the Bill says, a “clear, settled and informed” decision. There is a very strong argument that in order to do so, the panel should hear from the person themselves. That is the decision I have taken, addressing the concerns of colleagues who have tabled amendments to the same effect. Indeed, Lord Munby said of the Bill as it stands that

“the absence of any requirement that the judge ‘must’ hear from and question the patient is a quite extraordinary lacuna.”

I appreciate, though, that there will be exceptional circumstances, which we know may be the case if the patient is very ill and in their last few weeks of life.

The panel may also ask any person who appears to have relevant knowledge or experience to report to it on such matters relating to the person as it considers appropriate. It can basically ask to hear from anybody it wishes. That would obviously vary from case to case. Every case will be different, as we have discussed, and flexibility is really important. Only if all three members of the panel are satisfied that all the criteria have been met will it issue a certificate of eligibility. It must refuse to do so if it is not satisfied. The decision of the panel has to be unanimous. If there is any doubt from any of the panel members that the criteria have been met, the patient cannot proceed.

The patient then enters a 14-day period of reflection, before making their second declaration. It is worth reiterating that, as has been said previously, a significant number of patients get to that stage and never actually continue with an assisted death, but the comfort it provides enables them to live out their final weeks and days with a sense of reassurance. As families have described, a weight is lifted. Indeed, Professor Michael Dooley, who is the director of pharmacy at Alfred Health and the head of Victorian voluntary assisted dying pharmacy services, and who some of us met yesterday, told us that in that state in Australia some 90% of assisted dying patients also still access palliative care. That shows the holistic approach that can be taken.

There is of course another very important role for the commission, which is in relation to the monitoring and reporting of cases—something I feel very strongly about. The details are set out in my amendment 455 to clause 34. The commission must produce an annual report, which must include details about the application of the Act. That report must include details in relation to persons who have protected characteristics, and details of any other description of people specified. That would include data on demographics; statistics on the populations and characteristics of the patients who have chosen an assisted death; their age and gender; geographical analysis; data regarding the illnesses and diseases; how many cases were rejected; and how many patients did not complete the process and so on. When completing the annual report, the commissioner must consult the chief

medical officers for England and for Wales, and anyone who represents the interests of people with protected characteristics.

The Law Society, which is neutral on assisted dying, says that if the law were to change, the system must have “robust, accessible and independent safeguards”

as well as

“strong independent monitoring and review mechanisms”.

I agree. The introduction of a multidisciplinary panel of experts to consider all applications for an assisted death, overseen by a commissioner in the form of a High Court judge, sitting or retired, really does achieve that, and embeds a truly robust, multidisciplinary approach, which I am confident will put patients at the centre of the assisted dying process and provide additional scrutiny, safeguards and protections.

5.45 pm

Naz Shah: I rise to speak to new clause 21, new clause 14, new clause 16, new schedule 2 and amendment (b) to new schedule 2. I will start with new clause 21—and have a break in between.

I oppose new clause 21, tabled by my hon. Friend the Member for Spen Valley. I also wish to oppose new clauses 14, 15, 16 and 17, which between them set out the panel procedure to replace the use of a High Court judge, but I will focus my remarks on new clause 21. That is because, first, it is the most recently tabled of my hon. Friend’s new clauses on the panel. Secondly, and perhaps more importantly, it seems to be an attempt to solve some of the problems of the earlier new clauses.

I welcome what I think my hon. Friend’s intentions are with the new clauses. The Bill as drafted did not provide anything like adequate safeguards. The new clause states that the panel must hear from, and may then question, the doctors who made the certification, the applicant for assisted death, and any other person who may have relevant information. These moves are very welcome steps towards a tighter set of safeguards, but they are inadequate because of what they leave out.

Sir James Munby, the former president of the family division of the High Court of England and Wales, has written several times about the problems with the Bill. It is a matter of great regret to me that we did not hear from Sir James; I appreciate that my hon. Friend the Member for Spen Valley set out that he was invited to give evidence to the Committee. Sir James has expressed profound concern about the series of new clauses—new clauses 14, 15, 16 and 17—that my hon. Friend has tabled. He wrote that the new clauses did address some of the problems of the original Bill, but he went on:

“These changes are to be welcomed, so far as they go. It is important to recognise, however, that they do not, in my opinion, go anything like far enough.”

As I have said, some elements of new clause 21 do indeed address some of the problems that Sir James identified but, again, the new clause unfortunately still leaves many of the biggest problems untouched.

The Bill does not set out that evidence must be heard under oath. That is an extraordinary omission. Sir James Munby asks, in his most recent essay:

“is the panel to hear evidence on oath? Indeed, will the panel have power to administer an oath?”

We rightly expect our courts to hear evidence under oath if they deal with cases concerning property or contract. The matters the panels will be dealing with are far more important than that. It is baffling to me why we should hear evidence on these matters without making witnesses swear oaths to tell the whole truth and nothing but the truth. Anyone speaking to one of these panels should do so with the same commitment to telling the truth as they would in a court of law.

Danny Kruger *rose*—

The Chair: I call Kit Malthouse.

Danny Kruger: Danny Kruger; we are easily confused. *[Laughter.]*

The hon. Lady talks about the question of oaths, and it is extraordinary. Does she agree that it speaks to the confusion about whether the panels are a judicial construct at all? They have a judicial function—they exercise a judicial responsibility—but they are composed of non-lawyers. Maybe that explains why there is no oath, but I agree with the hon. Lady that there should be one. Does it not speak to the confusion in the new clause?

Naz Shah: As I make progress, I will speak to that point, but I share the hon. Gentleman's concern. I will return to my speech and expand on the point when I arrive at that juncture.

Sir James goes on to say that there are even graver problems with the panel procedure. I appreciate that his paper was published before new clause 21 was tabled, but it does not address all the concerns he raised. He referred particularly to new clause 16, but it is relevant to note that the problem he identified is left untouched by new clause 21. Sir James says of new clause 16:

“It says very little about the procedures to be adopted for testing and, if need be, challenging the evidence”.

He goes on to say that

“it says nothing about who should exercise that function; nor about the nature of any independent evidential investigation and nothing about who is to undertake this and who is to pay for it.”

Finally on this point, he says that new clause 16

“says nothing about what, if any, public funding arrangements there will be for the applicant, the two doctors, and any other parties or expert or lay witnesses.”

The first point raised by Sir James is an extraordinary one. The panels will bring together three people: a lawyer, a consultant psychiatrist and a social worker. They will sit on what is a quasi-judicial body. The latter two will not necessarily have any experience of questioning witnesses and assessing evidence as part of a quasi-judicial process. The first person—the lawyer—will have such experience. What is going to happen? Are we just hoping that they will successfully make it up as they go along? Is there not a danger that in some cases the non-legal members of the panel end up deferring to the wishes of the lawyer, who has more experience in these matters?

Kim Leadbeater: I appreciate the point my hon. Friend is making, and it is a shame that we did not hear from James Munby in evidence. I understand why he says that: he is looking at it through a judicial lens, because he is a judge. But this is not a judicial entity. It is a panel—it is not a court—and the range of expertise on it is actually a strength, not a weakness.

Naz Shah: As I make progress I will address some my hon. Friend's points—I have a fairly long speech—but I will say now that when the Bill passed on Second Reading, one of the safeguards was that it included judicial oversight. That is very different to what we are talking about now.

Danny Kruger: This is a very important point, and I am grateful for the hon. Member for Spenn Valley's admission that this is not a judicial process. We have constantly been told that the Bill has been gold-plated with the judicial stage of the application process, but we have now heard that there is not a judicial stage. We have also heard that this is “judge-plus” and somehow an improvement—it is a judge and others—but we should be clear that there is not necessarily a judge in the process, and it is very unlikely that there would be. We have just heard conclusively that the judicial stage of the process in the Bill has been dropped.

Naz Shah: I agree: there is not a judicial process, so to speak. There most definitely is not. As I make progress, I will outline my concerns about that very clearly.

Let us take the second point raised by Sir James. He asked who will go about

“testing and, if need be, challenging the evidence”?

New clause 21 finally gives the panel the power to call people to give evidence who are neither the applicant nor the doctor. New clause 21(4) says that the panel

“may hear from and may question any other person”

and

“may ask any person appearing to it to have relevant knowledge or experience to report to it on such matters relating to the person to whom the referral relates as it considers appropriate.”

I welcome that as a start, because it acknowledges that there will be cases in which people other than the applicant and the doctors have vital information. But that really should not be where we finish—not if we want a genuinely robust assisted dying Bill with strong safeguards for vulnerable people.

The ability of the panel to hear evidence from other parties would indeed be one step towards detecting whether people are, for example, being coerced towards an assisted death. That would be one step towards being able to detect whether people were choosing assisted death because of a lack of palliative care or social care. But how will the panels know which witnesses are most likely to have or be aware of the significant evidence they seek?

The panel members will have the statements by the applicant and the doctors, and they will have the answers to any questions they have of the applicant and the doctors. I ask Members to think through how certain it is that those sources alone will be enough to find all the people who might have significant knowledge of a person's circumstances. I would argue that it will not be certain. Yes, in some cases there will be no hidden circumstances that a panel would hear of from a witness only if they were called, but in other cases there will be, and those circumstances are much more likely to occur in the cases of people who are coerced or who feel like a burden to their families. They will be more likely to occur for those who have poor mental health, who are isolated, or who lack the social care they need. The panels are not likely to find witnesses with relevant

[Naz Shah]

information if what they have to go on is the statement of witness evidence of a person who has, for example, been successfully and skilfully coerced.

Dr Marie Tidball (Penistone and Stocksbridge) (Lab): New clause 21(4)(e) says that the panel

“may ask any person appearing to it to have relevant knowledge or experience to report to it on such matters relating to the person to whom the referral relates as it considers appropriate.”

Does my hon. Friend not agree that the expertise of the three panel members, as set out in the new clause, will mean they will very much have the ability to identify, on the basis of that subsection, the kind of individuals and the knowledge required?

Naz Shah: As I have stated before—I will make reference to that very point later—I would argue the safeguards are just not robust enough.

There should be a mechanism for trained and experienced people to find witnesses who might have relevant information. This could relate to another criticism that Members have made of the panel system: there is no provision for the Official Solicitor to act on behalf of the applicant. Sir James Munby argues that we should strongly consider this, saying that

“there must be a rigorous procedure in every case for testing and if need be challenging the evidence, including an independent evidential investigation, perhaps by the Official Solicitor, of the kind discussed in Conway. There are two reasons why this is essential in every case...Without this, it will not be proper for a judge to be involved in the process as a member of the panel.”

He goes on to make it plain that by “judge” he means the legal member of the panel.

Kim Leadbeater: I appreciate that this is slightly difficult to get our heads around, but we have legal expertise—we potentially have a judge, a sitting judge, a retired judge or an eminent KC—but they are not there in their capacity as a judge. I understand that that is tricky for people to understand, but they are there because of their skillset. That is the important distinction.

Naz Shah: That is the very distinction I am trying to highlight further, because the panel takes away the judicial oversight. Yes, they have expertise—there is no question about people’s expertise—but Sir James Munby says clearly that these people will not be sitting in their capacity as judges, as my hon. Friend just outlined, but just as experts. That does not provide judicial oversight. That is not what the panel does.

Kim Leadbeater: My hon. Friend is absolutely right, and that is the whole point: Sir James Munby said he did not think that was the job for the judge.

Naz Shah: I will go into this in even greater detail in later speeches, but I will say now that although the process was not fit for purpose, Sir James Munby also says that this one is not fit for purpose. Neither process gives us the legal aspect—if anything, the Bill has been watered down. As I make progress, I will outline how I think Sir James Munby’s evidence is clear that the safeguard has been watered down. I appreciate the

mood in the room while I insist on talking about this, but it is very, very important, because when we voted in the House to send the Bill to Committee, one of the biggest reasons why we did so was judicial oversight. Many Members have said that they let the Bill get to this stage because of that.

Kim Leadbeater: Will my hon. Friend give way on that point?

Naz Shah: I will make some progress. As it is, we have removed the judicial oversight. I appreciate what my hon. Friend says about the panels having expertise, but that is not judicial oversight.

6 pm

Sir James Munby continued:

“For otherwise, the judge, and, indeed the panel, is little more than a rubber stamp providing a veneer of judicial approbation—and that is fundamentally unacceptable. I appreciate that there is a question (which I need not explore) as to whether the legal member of the panel is fulfilling a judicial function. For present purposes it matters not. A legal member of a panel who is a judge or former judge will inevitably be thought of as a judge and in this context it is the appearance to the general public that matters.”

He went on to say:

“Even more fundamentally, without a rigorous procedure of this kind the panel will not be able properly to exercise its functions as mandated by NC16(2).”

He explained his reasoning:

“How confident can we be that the procedures set out in NC16 and elsewhere in the Bill will be adequate to enable the panel to identify and prevent possible abuses and in particular be adequate to detect what may be very subtle external pressures? My answer is very simple. Only those who believe implicitly in the omniscience and infallibility of judges and of tribunals such as the panel—and I do not—can possibly have any confidence in the efficacy of what is proposed.”

Such a provision for the Official Solicitor’s representative to appear would make it much harder for panels to miss information about an applicant. Currently, we are in effect asking the three panel members to be investigators, judges and jury. They will hear the evidence, decide whether they need to ask questions of the applicants and doctors, and based on that decide whether they need to summon other parties to speak. The picture that they receive of the applicant’s circumstances may miss key facts; that is not a responsibility that we can put on their shoulders alone. Amendments have been tabled that would permit the Official Solicitor to act on behalf of the applicant for assisted dying. If we care about making this a robust process that would protect vulnerable people, we should vote for them.

Lewis Atkinson: I think my hon. Friend just said that the amendments would allow the Official Solicitor to act on behalf of the applicant. Why would that strengthen the process?

Naz Shah: I think that by making some progress I will answer that question.

Turning to Sir James Munby’s question about what, if any, public funding arrangements there will be for the applicant, the two doctors and any other parties, experts or lay witnesses, each time a panel meets we will be asking three senior professionals to give up many hours of their time to scrutinise applications, listen to and perhaps question witnesses, and then decide whether to

call further witnesses. I could ask many questions about funding, but I will ask just one at the moment. Both Ministers will be well aware that courts and tribunals in England and Wales face lengthy delays—in some cases, delays of years. Will the Government commit to adequately funding the panel so that applicants do not face lengthy delays?

Another question about the resourcing of the panels is just as important: can we make good on the commitment in the Bill to provide a consultant psychiatrist for every panel? I think the answer may well be no. We spoke to the Royal College of Psychiatrists during our evidence sessions, but at that stage my hon. Friend the Member for Spen Valley had not tabled the amendments that would create a panel including a consultant psychiatrist, so we did not ask the professional body whether it would be able to do so.

I have had private conversations with my team of senior psychiatrists. We asked whether England and Wales had enough consultant psychiatrists to serve on each panel. They said it was extremely unlikely. I would like to understand whether my hon. Friend consulted the Royal College of Psychiatrists before she tabled those amendments. If she did not, that seems an extraordinary omission.

Ministers keep saying that the Government will release an impact assessment only when the Committee has finished amending the Bill. I say again: that seems to me a most unsatisfactory approach to a Bill that would lead to such a huge change. Surely the Minister could ask civil servants to prepare a preliminary estimate of how many applicants there might be in England and Wales. It should probably be phrased as a likely minimum and likely maximum number. That would be extremely helpful. Surely the Government could do the preliminary work on whether the psychiatric profession in England and Wales is capable of meeting that demand. I say this in the light of my understanding that the present state of the country's judiciary contributed to the removal of the judge in the first instance.

Kim Leadbeater: Just to be clear, that was not the reason for the change. We need to be very clear about that. The reason for the change was that it strengthens the Bill.

Naz Shah: That was not my understanding; I will come back to that point, because I am sure I have references to where that has been talked about. There is also the question of whether panels should be heard in public. Under new clause 16, the legal member of a panel would decide whether it should sit in public.

Finally, I return to Sir James Munby's paper on this question. As I have gone through in some detail, he raised significant concerns about panel procedures set out in new clauses 14 to 17. Unfortunately, it seems to me that most of those concerns have not been addressed by new clause 21. Sir James was a very senior judge, who headed the family division of the High Court, and is someone we should listen to with the utmost attention on these matters. He said:

"I appreciate that some may point to the multidisciplinary membership of the panel and to an assumption that the function and process of the panel may (it is said) be inquisitorial rather than adversarial. Plainly, it might be thought, it is an advantage that the panel has a multidisciplinary membership, and it is often said that three heads are better than one. Yet it would be a

mistake to think that either of these features of what is now proposed are sufficient to overcome the very real problems I have identified. They are not. What remains crucial is the substance, not mere appearances. If the panel is to perform its function effectively and do more than just 'check the paperwork'—if it is to be the real safeguard intended by its proponents—then its processes must be much more thorough than is currently proposed."

Lewis Atkinson: Has my hon. Friend had the opportunity to consider the functioning of mental health tribunals, which operate as panels in a very similar way to this proposal: chaired by a legal member with a specialist member and a medical member? They perform a similar quasi-judicial function, receive evidence and make important decisions on people's healthcare choices. Does she not agree that that model provides a good example of how this system could work?

Naz Shah: My hon. Friend's intervention takes us back to the concerns I already have. I understand that mental health tribunals relate to the Mental Capacity Act 2005, which would inform people on that panel in making their judgments. I have spoken extensively against the use of the Mental Capacity Act in this particular field.

Lewis Atkinson: I thank my hon. Friend for engaging on this issue, but this is not about the Mental Capacity Act; it is about the Mental Health Act 1983 and whether someone would be sectioned and denied liberty—a significant decision against the person's own wishes. That determination is made by mental health tribunals sitting in that judicial function, day in, day out, with exactly the sort of panel membership outlined here.

Naz Shah: I either misheard my hon. Friend or did not understand his earlier point, so let me speak to the point he makes now. My understanding is that sectioning someone under the Mental Health Act is a very extreme measure. Someone is sectioned in circumstances in which lots and lots of evidence has been taken from people who know the person, and there is a history. That was certainly the case when I chaired a mental health charity. Whether it is carers or other people who contribute to that, there is a long-standing relationship; from my understanding, it is very rare for something to happen otherwise. That is my understanding and experience of it, but I am happy to have a chat with my hon. Friend to talk more about it and understand it more.

Danny Kruger: Does the hon. Lady agree that the intervention of the hon. Member for Sunderland Central is very helpful because it highlights the difference between a genuine judicial tribunal, as he suggests, and what is being proposed here? This is not a tribunal. It would not sit in a judicial capacity. Its members would not take oaths in the way that members of a tribunal do. They are not appointed through the independent appointments process that tribunals have. This is a multidisciplinary team masquerading as some sort of final judicial stage, without the proper accountability of a judicial stage. On that basis, we cannot regard it as any sort of improvement to the Bill.

Naz Shah: I thank the hon. Member for reminding me of that; I talked about that earlier. I agree with him that this is about the legalities. Ultimately, it comes

[*Naz Shah*]

back to judicial oversight, which is what was promised originally. That is why judges were part of the original proposals for the Bill. The words we must listen to are Sir James Munby's. If we want an assisted dying Bill with real safeguards for the vulnerable, then we should reject new clauses 14 to 17 and new clause 21. They are not thorough enough to do the job.

The Chair: I should let the hon. Member know that I am happy for her to make five speeches, as she has indicated, but each one needs to be specific to the clause and not replicating the previous speech.

Sarah Olney: I will speak briefly about an important point that the hon. Member for Spen Valley made. I want to get it on the record that I disagreed with something that she said. We heard a lot in the evidence sessions about the desirability of a multidisciplinary approach or a multi-professional team, and I listened particularly carefully to Dr Sarah Cox, who gave oral evidence to the Committee on 28 January on behalf of the Association for Palliative Medicine of Great Britain and Ireland. She made important and interesting points regarding the desirability of the involvement of multidisciplinary teams in relation to her area of expertise: palliative care.

I am anxious that the panel that the hon. Member for Spen Valley is now proposing is being presented as a response to the comments of Dr Sarah Cox in relation to multi-professional teams, when it is clear that she meant something quite different. My interpretation of what she said was that the initial assessment should be done by a multi-professional team; what is being proposed here is something that happens much later in the process.

Kim Leadbeater: To be clear, the point I have tried to make with regard to the evidence that we received was just that there is a need for a multidisciplinary approach, wherever it happens.

Sarah Olney: I am glad to have had that clarification; however, it is really important to reflect on the fact that Dr Sarah Cox said that it would be considerably preferable to have the input of a multidisciplinary team at the earliest possible stage. That is not what is being proposed with these new clauses.

Kim Leadbeater: The point is that it has to happen at every stage, and I think the evidence that we heard was that it does happen. I know from the experiences of family and friends of mine who have had cancer that it does happen. There is a multidisciplinary approach; there is an oncologist, a nursing team and a doctor. That does happen, and nothing in the Bill will take away from that.

Sarah Olney: I thank the hon. Member, but I think she is responding to a slightly different point from the one that I made.

There was further written evidence from Dr Doré, the honorary secretary of the Association for Palliative Medicine, on 25 February. He wrote:

“To clarify any misunderstanding, the current Bill does not align with the standard multi-professional team...decision-making process used across the health service.

Under the Bill, patient assessments are conducted solely by two doctors without input from a wider MPT. While an amendment proposes the involvement of a panel—including a social worker and psychiatrist—this panel is introduced only at the end of the process and does not participate in the patient's direct assessment.

We wish to make it clear that the point that Dr Cox was making in oral evidence was that having two independent doctors, working alone, is not an adequate model to safeguard either patients or professionals, and that stipulating that the initial assessments must be carried within a multi-professional team model would strengthen the Bill.”

6.15 pm

Committee members will have heard me talk in previous sittings about the need for additional safeguards around mental capacity and those suffering from mental illnesses. I very much welcome the introduction of psychiatrists at any stage, but my point has always been that that intervention must come early—we need the psychiatrist's evaluation to be part of the initial assessment. I put on record that I do not believe that the amendments, new clauses and new schedules tabled by the hon. Member for Spen Valley address the concerns that I have raised on a number of occasions.

Kim Leadbeater: Does the hon. Member not agree that by accepting amendment 6, tabled by the hon. Member for St Albans, we have early intervention with psychiatric analysis at a very early stage, when either of the doctors feels it is necessary?

Sarah Olney: I am grateful for amendment 6 and to my hon. Friend the Member for St Albans for tabling it. I put on record, however, that I do not think that the panel that we are discussing addresses my earlier concerns. I wanted to make that absolutely clear by highlighting the further evidence from the Association for Palliative Medicine. The panel proposed by this group of amendments does not address its concerns, or the concerns of many other people who were saying that there needs to be a multi-professional team.

Jake Richards: I rise to speak in support of new clauses 14, 15, 17 and 21 and the accompanying amendments. I hope also to deal with some amendments tabled to new clause 21.

On Second Reading, I and many other hon. Members said that the Bill was the strongest and safest assisted dying law in the world. I want to be clear that I stand by every word of that, but this change will make the Bill far stronger and far more resilient to questions of capacity and coercion and therefore far safer. It will ensure a further independent layer of assurance: a panel of experts chaired by a senior lawyer to hold the process to account, to ensure that every avenue of inquiry has been explored and to hold professionals in our healthcare system to account when it is appropriate to do so.

The change will replace a single High Court judge, a person with no particular expertise in the issues at hand, with a panel that will adopt a more holistic approach. The social worker will delve a little deeper into the personal circumstances of each individual. The psychiatrist will ask any necessary questions about capacity.

They will serve alongside a senior lawyer to ensure that the process is necessarily formal and strict. They will have the powers to make further inquiries if they so wish.

On and after Second Reading, there were legitimate questions about the High Court function—what exactly were we asking the judge to do? I maintain that a High Court judge could have overseen the process, but it is far better and more pertinent to the issues at hand to have a multidisciplinary process involving a social worker and a psychiatrist.

This is our lawmaking process working efficiently: debate has pushed my hon. Friend the Member for Spen Valley to think again. Working with the Government—whose role continues to be to ensure that the Bill will be workable if it is to gain Royal Assent, while remaining neutral on the principle—she has been creative in tailoring a process to the matters at hand. That must be welcomed.

This is new law. The change that the Bill would enact is profound and therefore requires a very new safeguarding process. This is the key point. The panel would not be there to adjudicate on a dispute, undertake a trial or undertake an inquiry; it would be there to ensure that the process is safe. A person would come to the panel seeking assistance to which they are entitled under the law, and the panel would ensure that the process through which their eligibility has been decided has been rigorous and safe.

It is also important to note that the panel would simply regulate and scrutinise an ongoing doctor-patient relationship. Even after a certificate of eligibility has been received, there is a period for reflection and continued assessment. That is crucial, because it means that normal rules of appeal are not appropriate—I will come back to some of the amendments in that regard. Even once the panel's work is done, the co-ordinating doctor and the commissioner will remain available for reconsideration and oversight.

I want to deal with some of the criticisms that have been levelled at the change set out in the amendments tabled to new clause 21 and others. To my mind, the process should not be adversarial, because it is inherently inquisitorial. What is the dispute that is being decided? The person is deemed to have capacity by two doctors, and perhaps a psychiatrist, to make a decision, and is seeking an eligibility certificate. The starting point must surely be that the person should be allowed to do so. To set up some bizarre dispute where none exists would be counterproductive and unsettling to the person at the centre of the process. It would be a waste of public funds, but more importantly it would be a waste of time—time, in the context of a person who is dying.

The process is not analogous to the Court of Protection, where there are disputes as to capacity, best interests and welfare. It is not analogous to a court approval hearing, where there may be legal arguments as to the appropriate nature of an award or the arrangements for it. It is not analogous to a deprivation of liberty order, where in all likelihood a person would seek not to be deprived of their liberty. It is not analogous to private children's proceedings, where the child's welfare is paramount. This is a person seeking help for themselves. The principle of choice and autonomy at the end of life means that that process must be patient-centred and begin from an appreciation of those principles.

Danny Kruger: The hon. Gentleman is making a very good speech in defence of the change, but could he help me understand something? He said that he supported the previous proposal, involving a High Court judge; he is now suggesting that it would be completely inappropriate to have any sort of judicial oversight of the process. How could it have worked better?

The hon. Gentleman talks about there being no need for any sort of adversarial system, but does he not recognise that there might be another side to the story, and that it would be appropriate for somebody, whether that is a judge or someone else, to hear arguments against the application?

Jake Richards: Let me deal with the first point first. A High Court judge could have exercised this function themselves. As I set out in public very soon after Second Reading, I was struck by the fact that we were asking a High Court judge to do this, even though they have no particular expertise in the issues that so concerned hon. Members on Second Reading, whether they voted in favour of the Bill or against it. I thought about the process more, as we are all doing, to try to understand what it would look like in practice. What questions might be asked? Where does a panel or judge need to go? To my mind, psychiatrists and social workers are much better placed than High Court judges to know what avenues to further explore.

I have forgotten the hon. Gentleman's second question.

Danny Kruger: I was making the point that there is surely some value in what the hon. Gentleman describes as an adversarial process, in which the decision maker is required to consider whether there are circumstances that the applicant is not presenting.

Jake Richards: I will come on to that issue. First, there are avenues for the panel to have information put before it that will be pertinent to the decision at hand and that may be pivotal to that process. That is not quite adversarial. Secondly, there is always a route for an adversarial contest in this matter through judicial review. I hope that that will be very rare, but it is certainly possible, and that has to be maintained. I think my hon. Friend the Member for Spen Valley and the Minister would accept that that would be an avenue.

The panel will have an array of information to consider. It will have two reports: one from the co-ordinating doctor and one from the independent doctor. In any event, it is often likely to seek medical records. It will speak to the co-ordinating doctor or independent doctor about capacity and any issues of coercion. Crucially, it will speak to the person themselves unless there are extraordinary circumstances that oblige it not to. One can imagine the vast array of circumstances that will come before the panel, but it will have the discretion and freedom to explore as appropriate. That will be a process that is appreciative of the specific facts before the panel.

I made this point earlier, but it is important to remember that this is a very human moment. A person is dying; they come to the panel seeking help. It is right to ensure that there are hurdles to consideration for eligibility, but the idea that a person should be forced to win a trial or a case, or see through complex litigation, is surely not right.

Kim Leadbeater: My hon. Friend is making an excellent and powerful speech. I thank him for putting the human being back at the centre of the process; sadly, in this Committee we can forget to do that. Early on, we had Nathaniel Dye here, who is a terminal cancer patient. He has just had a 12-month prognosis. The thought of making that man jump through hoops and over hurdles breaks my heart. I understand that we have to do it, but these are the people that we are actually talking about when we discuss the Bill.

Jake Richards: I agree, and I hope to deal with some of the points that my hon. Friend made in her important speech. To mandate that a barrister instructed by the Official Solicitor, or indeed the panel, has to put questions to a person who may have only a few weeks left to live is not only highly inappropriate, but unworkable. What instructions is this barrister working from? Do they have to suppose that somebody who clearly has capacity does not? If not, do they ask questions about the circumstances of the person that would be asked by the panel in any event?

My hon. Friend the Member for Bradford West suggested that the Official Solicitor would be working for the person. Well, the person is coming to this panel seeking assistance, so what on earth is the Official Solicitor or their legal representative going to ask of the person they are taking instructions from? To what extent would they be allowed to go on a fishing expedition, delving deep into a person's relationships to assess any evidence of coercion? That goes back to my original point: what are their instructions? Who is asking them to do what?

I see the force in the amendments from my hon. Friend as to burden of proof, but I deem them inappropriate. The criminal standard does not fit neatly with the more complex issues at play, such as capacity. The Mental Capacity Act states that where there is a doubt about a person's capacity, the burden of proof is on the person seeking to establish a lack of capacity, on the balance of probabilities. That is the correct approach. In any event, if the panel has any doubts as to capacity, surely it will be obliged—as is set out in amendment 6 to clause 9, which the Committee has just accepted—to seek further psychiatric assessment. It is important to note that the panel will have powers to instruct further expert assessment and reports.

If we implement the criminal standard, the doctors who are part of the process—not only the co-ordinating doctor and the individual doctor, but treating doctors, because we should always remember that someone who is terminally ill will almost certainly be receiving treatment in the NHS—will be working to a completely different burden of proof from the panel's. The criminal standard does not fit neatly with the innately inquisitorial nature of the panel's role. That is important. It is very easy to look at the definition of the balance of probabilities and find weaknesses in it, but when we consider what actually happens in practice, I submit that those weaknesses are not often there.

The panel will have a conversation with the professionals and with the person and will consider the response. If doubts creep in, it will not just stop and make a decision on the balance of probabilities; it will continue to search. The more serious the doubts it encounters, the more evidence it will need for those doubts to be overcome. That is how the law has developed on the balance of

probabilities in all other areas, and no doubt it will be the same in this area. Importantly, unlike with many other tribunals or courts, the decision must be unanimous, so if the social worker spots something that the psychiatrist or lawyer does not, the case will go no further.

What about the role of third parties? As I have set out before, this is a personal decision, but I also accept that no man is an island—a phrase often used by the hon. Member for East Wiltshire. The process has to strike a real balancing act: allowing third-party information to be considered, but in a proportionate manner that respects individual autonomy. To my mind, the views of third parties are not relevant. Their views on whether the person is making the best decision for themselves are not relevant. This is not a welfare decision. Equally, it must be right that third parties—family members and others—can ensure that the panel has sight of the relevant information. Even after a certificate of eligibility has been given, the co-ordinating doctor will continue to be responsible for assessing new information, and their duties will continue until the final moments, as the Bill sets out.

6.30 pm

Naz Shah: Given my hon. Friend's expertise, does he anticipate JR being allowed in the panel setting? If so, would it be before the death or after? Can the decision by the panel be judicially reviewed?

Jake Richards: In my mind, any decision to give a certificate of eligibility could be subject to judicial review.

Third parties can put evidence before the panel to be considered, but it is not right that third parties might challenge the application. As I have set out before, this is not a dispute but a rigorous safeguarding process. If they have information about the person's capacity, their diagnosis or any other relevant factors, they can and must ensure that the panel—if not the doctors or indeed the police—be seized of the information. Third parties can appeal the decision by way of judicial review. That would provide for a decision that was

“wrong, or...unjust because of a serious procedural or other irregularity in the proceedings”,

per amendment (a) to new clause 17. An injunction would be applied and the matter would have to be dealt with expeditiously. It is worth saying that all the evidence suggests that that would happen incredibly rarely. In Spain—

Daniel Francis: My hon. Friend is about to refer to Spain, as am I. Article 10 of the relevant Spanish law gives a right of appeal on a point of law to a higher court. Does he believe that we will be in line with the position in Spain? How long does he envision judicial review taking, given that we are dealing with somebody who is at the end of their life?

Jake Richards: The answer to my hon. Friend's question is yes: judicial review is clearly an exercisable option in this case. I said “expeditiously” because lots of cases are heard expeditiously; High Court judges hear cases in the middle of the night, if there is a certain urgency. In these cases, one might imagine similar circumstances, but I must stress that they would happen incredibly

rarely. All the evidence suggests that. In Spain, where a not dissimilar model is in place, such an approach is rarely used by family members. The vast majority of families attend the panel because they want to offer support and love to the person who has made the choice.

Daniel Francis: I just want to confirm that either side has the right of appeal in Spain.

Jake Richards: Yes.

The other side of the coin is that we must ensure that the process is workable. In Spain, 20% of people die before the panel hears their case. We must be very careful not to create something that is so burdensome as to be completely pointless. I believe that the amendments tabled by my hon. Friend the Member for Spen Valley aim successfully between ensuring flexibility and rigour. Each case will be different—more so than in any other set of proceedings that I can imagine, and I have thought hard. There will no doubt be some that are incredibly complex, in which the panel may require further assessments and hear from relevant experts, but there will be far more that are solemn and serious but straightforward, and that is correct.

Other amendments, such as amendment (d) to new clause 21, in the name of my hon. Friend the Member for Derby North, seek to mandate certain procedural steps. While I have great respect for her as a former colleague, I fundamentally disagree with her amendment, which would require that the panel “must consider” hearing from persons who may be “interested in the welfare of the person”.

I repeat that this is not a welfare decision. The panel, just like the High Court judge, is not saying, “What do I think is in the best interests of this person?” It is ensuring that the person has made the decision per clause 1, where we started: “settled”, “informed” and “voluntary”. We enter new ground with this law change, and that is why it is a new process, but to my mind it is safer and workable. Colleagues can be reassured, and I urge people to support the change.

Lewis Atkinson: I thank my hon. Friend for giving way at the end of an excellent speech. Does he agree that the provision in new schedule 2 that allows the commissioner, who would be a sitting or previous judge, to give guidance and set procedure for the operation of panels would answer some of the concerns raised by those who think that there would not be sufficient judicial input into the procedure of the panels?

Jake Richards: That is an important point, because the change, as drafted in the various amendments, provides for real flexibility. That may cause others some concern, but to my mind it is a reassurance, because it will mean that a weighty figure, the commissioner, will be able to set out rules and regulations for the process to make sure that it is rigorous but is not so burdensome as to be pointless.

Liz Saville Roberts (Dwyfor Meirionnydd) (PC): I rise to speak to my amendment (a) to new schedule 2. The assisted dying review panel comprises a legal member and the chair, a psychiatrist member and a social worker member. I welcome this third tier of safeguarding and its range of specialities, as laid out in new clause 21.

My amendment (a) would amend paragraph 4, which concerns membership of panels, by inserting a new paragraph 4(3):

“Each member of a panel must have fluent proficiency in the Welsh language if services or functions in the Act are to be provided to an individual in Welsh.”

I emphasise the “if”, because it is in certain circumstances. I have previously touched on the requirements of the Welsh Language Act 1993 and the Welsh Language (Wales) Measure 2011. It appears that the panel can be defined as a legal proceeding and will therefore be required to follow the pre-devolution 1993 Act. Let us consider whether that is sufficient for the level of safeguarding that all Committee members want to provide.

Section 22(1) of the Welsh Language Act 1993 states:

“In any legal proceedings in Wales the Welsh language may be spoken by any party, witness or other person who desires to use it, subject in the case of proceedings in a court other than a magistrates’ court to such prior notice as may be required by rules of court; and any necessary provision for interpretation shall be made accordingly.”

I quote that as the nearest comparator. That means that the 1993 Act, in the situation we are discussing, enables people to speak Welsh and for interpreters to be provided as necessary. That gives people the right to speak Welsh, but it does not give them the right to be heard in Welsh in their own voice. If the legal personnel do not speak Welsh, their decisions will be based on the interpreted communication. The key question is whether we are content to accept the use of interpreters as intermediaries between the individual and the assisted dying panel.

Dr Sarah Davies, a consultant respiratory physician from Colwyn Bay, has written, with 78 other clinicians from Wales as co-signatories, to parliamentarians about their concerns. She states:

“In practice use of interpreters does not provide full communication of appropriate knowledge from clinician to patients. This is because interpreters are often not experienced and confident enough to discuss such complex and legal issues as assisted dying. Even the best possible practice by interpreters cannot match communicating in the person’s own preferred language. Every person whose preferred or primary language is Welsh and who communicates as a family or socially in Welsh should have access to important health information in Welsh. Any necessary assessment of capacity for purposes of consideration of assisted dying, and any assessment of coercion, must be in person and in Welsh if that is the person’s preferred language.”

Dr Davies further states that it is not possible to confidently assess the decision-making capacity of a Welsh speaker in their second language. Superficial conversations in English often fail to demonstrate that a Welsh speaker with significant health problems is confused or does not have a good understanding of their own health condition and treatment options. The presence of confusion or lack of information may become apparent only during detailed conversations with a Welsh-speaking healthcare professional. It can be extremely challenging to detect the presence of coercion, and the nuances of family dynamics will not be apparent to a non-Welsh-speaking professional when the language spoken in the family is Welsh, so it will not be possible to make any assessment of the presence or absence of coercion. That is what Dr Davies says.

The office of the Welsh Language Commissioner believes that there must be provision in the Bill to ensure that a person’s choice of language is considered, recorded and matched with further provisions, including

[Liz Saville Roberts]

a Welsh-speaking specialist panel. The commissioner's office agreed that such an amendment relating to the specialist panel is very important. It stressed that a Welsh-speaking panel will be able to provide the same service in English to individuals who are not receiving assistance through Welsh, so the requirement in amendment (a) should not, in and of itself, necessarily mean recruiting more individuals or more panels. None the less, I feel that I must allay fears that it would require every member of every panel in Wales to be able to speak Welsh. It does not. That is not the intention of the amendment, nor is it in its wording. Fluent proficiency is required of all panel members only when the panel is making a decision in relation to a person whose preferred language is Welsh.

So far, the response I have received from Ministers is that this private Member's Bill does not require specific requirements on Welsh language rights in it and that these rights are already enshrined in law. The hon. Member for Chesham and Amersham and I have written to the Minister as regards discussing how the legislation should operate in relation to Wales and devolution—he had previously committed to a meeting—but we have yet to receive a response. I have withdrawn previous amendments in anticipation of that very meeting, but in this instance—as the provision of interpreters to communicate between the individual and the people charged with being the final guardians of safeguarding is wrong—I will push the amendment to a vote, because I do not believe that the issue is covered in legislation as things stand.

The Chair: I call Naz Shah for part 2.

Naz Shah: Part 2 of five, I might add, Mrs Harris.

I rise to oppose new clause 14 from my hon. Friend the Member for Spen Valley. The clause would create the post of a voluntary assisted dying commissioner. It is quite an extraordinary clause, and I am not sure we have seen anything like it in recent legislation. What I am sure of is that we have not seen a law as far-reaching as this introduced without any of the detailed work that should have been done on it by the civil service.

The voluntary assisted dying commissioner—I will call them the VAD commissioner—created by the new clause would have unusual powers. The commissioner would select the members of the panel, who would in turn decide on people's assisted dying applications. The commissioner would be the authority to whom people could appeal if their application was refused. The commissioner would also decide if particular panel members had made any mistakes or shown any misconduct in their work.

In this country, we do not give one person the job of selecting judges, overseeing their work and then functioning as a court of appeal, even if that one person is extremely well qualified. That is for good reason. But the new clause suggests giving all those powers to one person. Hon. Members might object and say that the comparison is not exact, and that there will be fewer assisted dying cases heard by the proposed new panels than there are cases heard before the courts, but that misses the point. We do not put all the powers over the judiciary into the hands of one man or woman because it would be a lot

of work for them. No, we do not do that, because we do not wish to put too much power into the hands of any one person. However, under the new clause, we would do exactly that.

6.45 pm

That may sound like an abstract question, but it is not. One of the great concerns that hon. Members have expressed throughout this Committee is that the assisted dying process might fail to safeguard vulnerable people. Some hon. Members have expressed concern that people might opt for assisted dying because they were coerced or encouraged, or because of a lack of palliative or social care.

Let us say that the Bill, including new clause 14, passes. In that case, the Prime Minister will appoint someone as the voluntary assisted dying commissioner, and he or she will in turn appoint members to the panels. Let us consider what happens if someone successfully applies for assisted dying but, after their death, someone makes a credible allegation that they were coerced or suffered from a preventable lack of social care, or presents facts suggesting that there was a serious misdiagnosis by one of the doctors.

That is not a remote possibility; indeed, it seems very likely to happen at some point, given that we have had similar cases in all the jurisdictions where assisted dying has been going on for some time. That is why I intervened on my hon. Friend the Member for Rother Valley to ask whether there would be a JR process. If we are talking about a judicial review of any of the decisions by the panel in a case where somebody has less than six months to live, raising the funds and finding somebody to take that to court would potentially take time. Would that time elapse after the person's death or before? I would really value understanding from the Minister or the Bill's sponsor what safeguards there are for a potential JR. Have those been built in or not?

Danny Kruger: This conversation is very helpful, and the point the hon. Lady makes is absolutely right. If we are going to rely on JR as a sort of appeal process, we need to make it clear how that would work. Would there be legal aid? How quickly could these things be done? I think that that needs to be built in. Does she agree?

Naz Shah: I absolutely agree that we have not thought this through enough, because that process has not been laid out. We really need to think about these potential eventualities.

When such cases happen, the public, including family members of the person who has died, will rightly demand answers, and so will the media. They will want to know who the panel members were and why they made the judgment they did. In such cases, who would investigate whether panel members had got it wrong? The commissioner who had appointed them? The commissioner, or any person, no matter how honest and how learned, would come back to that question with a very strong bias. The commissioner will mark their own homework. That is not a system that anyone can argue will provide proper safeguards.

Hon. Members might object that the voluntary assisted dying commissioner will be a very senior judge. According to the new clause, the commissioner

“must hold or have held office as a judge of—
the Supreme Court
the Court of Appeal, or
the High Court.”

I agree that only people of high intelligence and good standing become judges in those courts, but that does not mean that the very highest judges in the land do not sometimes make mistakes—sometimes very bad ones.

Jack Abbott: If we follow that argument, does that mean that we would support the new clauses? If we are moving from that single point of reference—a High Court judge and judicial review—it is surely much safer to move to what is proposed.

Naz Shah: The truth is—I said this in my previous speech, which I will not repeat, as instructed by you, Mrs Harris—that neither of the safeguards is strong enough. As it was, the Bill was not strong enough—that has been recognised and changes have been proposed—but neither is the idea of a commissioner.

There is another great problem raised by this set of changes to the Bill: they seem likely to increase the prospect of group-think when it comes to members of the panel. I would argue that that danger has been greatly increased by the move away from the High Court judge model that was originally in the Bill.

When my hon. Friend the Member for Spen Valley introduced the Bill on Second Reading, she reassured the House that all assisted dying applications would have to be examined by a High Court judge. There were problems with that proposal, which is why she abandoned it. But there was one strength in making a High Court judge the arbiter: the Crown does not appoint High Court judges on the basis of whether they agree with assisted dying. We could all reasonably expect High Court judges to have a range of views on assisted dying; there is no reason I can think of that would mean that High Court judges, as a body, were biased in favour of assisted dying.

Something different will happen if a commissioner selects people to serve on these panels. Anyone serving on a panel will know that they will have to approve some applications for assisted death. We do not know how many applications for assisted death the Government expect to have. We also do not know how many social workers, psychiatrists and lawyers would be unwilling to approve any assisted death applications at all—I do not want to repeat myself, but I will be referring back to psychiatrists in another amendment. However, the number of psychiatrists who are strongly opposed to assisted death is very high, according to the Royal College of Psychiatrists. We have also heard strong reservations expressed by the Association of Palliative Care Social Workers. Therefore, many professionals will choose not to sit on these panels, because they will not want to approve any cases. That means that some panel members are likely to end up dealing with dozens of cases per year. That poses the danger that some of the people who sit most on these panels will be advocates of assisted dying and will approve applications that other members may not have.

Rachel Hopkins (Luton South and South Bedfordshire) (Lab): I thank my hon. Friend for discussing her view of the approach of the proposed panel members. Does she

recognise that all three of those professions have professional requirements to act with integrity and in accordance with the law? It is highly unlikely that they will push forward, as she seems to suggest, and risk their professional accreditation.

Naz Shah: I am not questioning people’s integrity; I am putting it to the Committee that people have biases. We all have subconscious biases. We have things that we like; we know that that exists, whether it is a subconscious bias or a conscious bias. As human beings, we all have that. In this instance, I am suggesting that if we have members of a panel who choose to be there because they have a fundamental belief, which is different from that of those who oppose assisted dying, there is a risk of subconscious bias and group-think.

Rachel Hopkins *rose*—

Jake Richards *rose*—

Naz Shah: I am happy to take an intervention from my hon. Friend the Member for Luton South and South Bedfordshire, and then I will come to my hon. Friend the Member for Rother Valley.

The Chair: Order. I call Rachel Hopkins for an intervention, but we need to keep to the point and not labour one particular thing.

Rachel Hopkins: The point I was making was that no professional would want to risk their professional accreditation and career by allowing a complete bias to take over any decision making. In fact, I would suggest that some may want to prove their integrity by being involved in these decisions and making them in line with their professional practice.

Naz Shah: I disagree with my hon. Friend. Subconscious bias operates in society; this is not about being held to account. People are not doing these things deliberately, but because they have a subconscious bias.

Jake Richards: My hon. Friend is making a fine speech. She said that High Court judges make mistakes, which is undoubtedly true. She also said that the panel may be guilty of unconscious bias. Is there any layer of scrutiny that would satisfy her? What does she think about jury trials?

The Chair: Could the hon. Lady make progress now, please?

Naz Shah: I am grateful for my hon. Friend’s intervention, but I reject the facetiousness of his point.

Let me speak to the issue of unconscious bias in relation to the proposal before us. In 1992, there was a jury trial, which found my mother guilty of murdering an abusive partner. In 1998, I went to the High Court and put it to three white middle-class judges that my mother could not tell the truth because of the abuse, the dishonour and the concept of *izzat*, which defined her existence as a woman. They were not capable of believing that, because they did not have that cultural understanding—so, yes, unconscious bias does exist, even in criminal cases in courts of law.

Returning to my argument, I remind hon. Members of the testimony of Dr Ryan Spielvogel from California, who said:

[Naz Shah]

“when I am going through the options with patients who are newly diagnosed with a serious life-threatening illness, I say, ‘Okay, here’s what disease-directed treatment would look like. We can continue with your chemo. Here are some side effects and complications that you might have, and here are the benefits of that. Here’s what palliative care or hospice care would look like.’ Then I say, ‘I don’t know if you know this, but in our state we have this other option for people nearing the end of their lives when they have intolerable suffering. You can ask me to fill a lethal prescription for you to help end your suffering sooner.’...The number of times that people look at me and say, ‘You can do that? That’s an option here?’ is astounding. I would say that nine out of 10 of patients I have conversations with have no idea that that is even legal. If they do not know it is an option, they are never going to ask for it.”—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 28 January 2025; c. 105, Q143.]

I wonder whether I would be comfortable—this is just a personal thing, but I want to put it out there for people to think about—about a doctor such as that, who really supports assisted dying, being on the panel. I am not casting aspersions on him, but I genuinely am unsure.

Of course, the panel will be chaired by lawyers. I would like to remind hon. Members of the evidence of Professor Meredith Blake, who is a senior legal adviser to the Western Australian government on their assisted dying law. Professor Blake’s evidence was quite extraordinary. My hon. Friend the Member for Banbury asked her:

“Does it concern you that a large proportion of people who opted for assisted dying cited being a burden as their reason?”

She replied:

“That is not the evidence that we have got.”

My hon. Friend responded:

“Let me just clarify. The state’s own report in 2023-24 had 35%.”—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 30 January 2025; c. 220, Q284.]

I do not recall having a satisfactory answer from Professor Blake to that question, but please feel free to check *Hansard*.

If we see a series of questionable decisions by one or more panel member, the only official scrutiny will come from the person who appointed them to do their jobs, and that is not a robust safeguard. Furthermore, my hon. Friend the Member for Spen Valley said earlier that decisions would be unanimous, but that is not entirely correct, and I am happy to point to the relevant bit in the Bill. If two people decide they agree, and the other decides to stay quiet, that would be seen as a unanimous decision, and the panel would proceed. I am happy to point that bit of the Bill out to my hon. Friend, as I would love to see an amendment if one were needed.

Danny Kruger: I think the point the hon. Lady is making is that each member of the panel has a veto over the decision so, in a sense, there has to be unanimity about the approval. However, she is absolutely right that if two members disagree with one another about any other aspect of their proceedings, including who to invite to give evidence, they could be overruled, so there is not unanimity there.

Naz Shah: I completely agree. That is the case in the Bill, which raises concerns.

Finally, Parliament needs to get back into the habit of holding powerful commissioners accountable. There is no mechanism in the Bill for removing a commissioner even if they somehow failed significantly in their duties. We might say to ourselves, “If that happened, they would do the right thing and resign,” or, “They would resign if the Prime Minister said something in public.” I am sorry, but we cannot leave that to chance.

There has been a very telling example recently of just how badly quasi-judicial institutions can fail, and just how hard it is to get their senior leadership to accept responsibility. The Criminal Cases Review Commission mishandled the Andrew Malkinson case. Mr Malkinson was falsely convicted of raping a woman in 2003. She had been raped by another man.

The Chair: Order. Can the hon. Lady keep to the issue?

Naz Shah: This relates to my point, Mrs Harris, I promise you. DNA evidence subsequently proved that Andrew Malkinson was indeed innocent, yet he was allowed to remain in jail.

Members of this House expressed serious disquiet about the conduct of the chairwoman of the CCRC, Helen Pitcher, over the Malkinson case. In July last year, my right hon. Friend the Justice Secretary called for Ms Pitcher to step down, but she refused to do so and remained in office until January. I note that Ms Pitcher remains chairman of the Judicial Appointments Commission—and that is where the link is.

7 pm

Jack Abbott: My hon. Friend is saying that there is no mechanism to remove the voluntary assisted dying commissioner. Actually, paragraph 4(5) of new schedule 1 says:

“The Secretary of State may by notice in writing remove a person from the office of Commissioner or Deputy Commissioner if satisfied that the person—

(a) has behaved in a way that is not compatible with their continuing in office”—

I think that addresses a lot of the concerns that she has been expressing—

“or

(b) is unfit, unable or unwilling to properly discharge their functions.”

There is a mechanism in the new schedule that would give the Secretary of State the power to remove the commissioner.

Naz Shah: I thank my hon. Friend for pointing that out, and I will look at it, but that was not my understanding.

There are multiple reasons to oppose new clause 21. With it, the Bill will reduce the impartiality that would have been provided by having a High Court judge rule on applications. It will increase the risk that a large number of decisions are taken by people who are enthusiastic proponents of assisted dying, which will reduce patient safety. It will also create a powerful new commissioner, who will appoint panel members and will then rule on whether they have made the right decision. That same commissioner will also be able to decide whether to overturn a panel’s decision to reject

an assisted death application. That is a huge amount of power to put in one person's hands and we should not do so. I urge hon. Members to reject the new clause.

Sean Woodcock: May I say what a privilege it is to have you in the Chair, Mrs Harris? *[Laughter.]* Clearly, I know how to win and lose an audience.

I rise to speak to amendment (d) to new clause 21, which has been tabled by my hon. Friend the Member for Derby North. I will start by saying how glad I am that the promoter of the Bill, my hon. Friend the Member for Spen Valley, has recognised some of the concerns regarding the multidisciplinary panel, and I welcome the improvements that she has made in the new clause.

I am pleased that the panel “must” now hear from the person to whom the referral relates, whereas previously it was the case that the panel “may” hear from them. That is a partial concession, but an important one. It will allow the commissioner to have greater scrutiny over the application and better assess the person's eligibility for assisted dying.

Amendment (d) is a technical amendment. We have discussed a number of such amendments before in this Committee, many of which have fallen for reasons that I understand, even if I do not agree with them, including on the basis that doctors are already having these conversations and we do not want to police them. The panel stage is brand new; given that and given the level of public scrutiny of the Bill, I make no apology for supporting putting something into primary legislation to say what is expected of this process. It is very important that we make sure from the off that we get things right.

I am deeply concerned about some of the potential oversights in the panel model. The purpose of the panel is to provide meaningful scrutiny of a person's application. The panel draws on a wider range of experts to assess the complex aspects of the application, such as assessing for coercion and capacity. However, the panel's ability to fulfil this scrutinising role is in many ways quite limited.

Amendment (d), which was tabled by my hon. Friend the Member for Derby North, would address the significant oversights in new clause 21. It would introduce a far more comprehensive set of requirements for the panel in its review. Those changes are not barriers to access; rather, the amendment would ensure that the panel has a far wider range of information—a theme to which I referred earlier—on which to review the application for an assisted death. Fundamentally, the amendment would give the panel more tools to conduct meaningful scrutiny.

However, let me list what the panel is not required to do under new clause 21. It does not have to hear from one of the two registered medical practitioners. It will hear from the other registered medical practitioner, perhaps via audio link, but it does not have to question them. Likewise, it will hear from the person, perhaps via audio link, but it does not have to question them. The person may have a proxy to sign their declarations, but the panel does not have to hear from or question the proxy. The panel does not have to hear from or question any other person. Let us be clear who that includes: the panel could assess the person's application without any information from the person's relatives, family members, friends, social workers or care workers.

New clause 21 states only that the panel “may ask any person appearing to it to have relevant knowledge or experience to report to it on such matters relating to the person to whom the referral relates as it considers appropriate.”

Subsection (4) makes it clear that, whereas paragraphs (a) to (c) require the panel to hear by live audio from the person seeking assisted dying, the evidence that the panel chooses to take from anywhere else could be in written form.

Let me draw out with an example what that might mean in practice. A person is diagnosed with a terminal illness—in this case, heart failure arising from coronary heart disease. Both doctors approve the person's application for assisted dying, on the balance of probability. The person has a physical disability and asks a proxy—a neighbour, say—to sign off the application. The first doctor speaks to the panel via video link restating the schedule forms and providing no new information. The panel then hears from the person, also via video link. It cannot see the person, but after hearing their statement it decides that it is satisfied that the conditions are met and approves the person's assisted death.

The panel has not spoken to the second doctor and has not put any questions to the second doctor or to the person applying for an assisted death. Incredibly, the panel has not spoken to the proxy, who may just be someone of good standing in the community. Nor has it spoken to the person's relatives, to anyone standing to benefit from the person's death or to anyone in the person's care. Any one of those people could have concerns that the person is being coerced into an assisted death. They may even have evidence of coercive behaviour. However, at no point is the panel required to consider speaking to any of those people.

Time and again, the Committee has heard from experts that coercion and controlling behaviour can be extremely difficult to detect. Often, the person will not reveal that they are suffering from that form of coercion, yet it is often those who are closest to the sufferer—a close relative, a member of the family or a social worker—who pick up the signals. Any of them could be looking out for the person's welfare and noticing them becoming more isolated and emotionally manipulated by another. At no point, however, does the panel have to consider hearing from that person. If this Bill is going to do everything to safeguard against the risk of coercion, as everybody on this Committee believes it should, that should change.

The panel must consider listening to the people closest to the person. Amendment (d) to new clause 21, in the name of my hon. Friend the Member for Derby North, would address those flaws by giving the panel a higher standard of scrutiny. The panel would have to hear from and question both doctors. It would have to question the person, not simply hear from them. If the person has a proxy, as under clause 15, the panel would have to hear from and question that proxy. Crucially, the panel would have to consider hearing from and questioning persons properly interested, and any other person who has provided treatment or care for the person being assessed in relation to that person's terminal illness. It would also be able to hear from and question any other person whom new clause 21 states can be asked to report to the panel.

The changes in the amendment would significantly improve the scrutiny provided by the multidisciplinary panel. It would provide a broader range and greater

[Sean Woodcock]

detail of evidence for the panel to base its review on. Ultimately, it would make the multidisciplinary review far more meaningful. Why is this greater scrutiny necessary? This is about protecting the vulnerable people who are easily forgotten. The amendment seeks to provide the strongest possible protection for them. This robust and comprehensive scrutiny is necessary to have a better chance of preventing the worst abuses.

I foresee one possible criticism from some hon. Members, which is that the amendment would slow down the decision-making process for people who are at no risk of coercion. That may well be true, but if the amendment is accepted, the panel would have to question both doctors, not just hear from one, and it would have to determine whether to hear from and question other people. In straightforward cases, in which the panel discovers no initial evidence that disquiets it, a small amount of time might be added to the hearing; in cases in which the panel finds evidence that means it may need to dig deeper, there could be a greater delay to the decision.

Personally, I do not see how we can avoid that. If we are serious about having safeguards to protect the most vulnerable, we should and must accept it. The process of vetting applications will take more time on average, and a lot more time in some cases, but the alternative is a simpler and faster system in which it will be much harder for the panel to detect coercion and other disqualifying factors. In that case, the chances will be higher that some coercive or abusive people will find it possible to push people towards an assisted death. Such a system is what we see in new clause 21, as drafted. We face an inescapable trade-off. We cannot lift protection for those who are most vulnerable to coercion because it would make the process easier for people who do not face that risk. I urge hon. Members seriously to consider supporting the amendment.

Sarah Green: I rise to speak to two aspects of this group of amendments. The first is the inclusion of social workers. When we first started receiving written evidence, I found the submissions from social workers the most compelling. I agreed with them that their profession has a key role to play in the process. I am pleased that they will feature on the panel: I believe that that will strengthen the safeguards in the Bill.

My second point relates to amendment (a) to new schedule 2, in the name of the right hon. Member for Dwyfor Meirionnydd. I was fortunate to grow up in a Welsh-speaking part of rural north Wales. I am a Welsh speaker, and Welsh is the first language of some of my friends, my neighbours and my family members. It is the language that they dream in, the language they count in and the language that they are most comfortable using, so when it comes to end-of-life conversations it is important that they can use the language in which they are most proficient and fluent.

Should an individual choose to access an assisted death through the medium of Welsh, they should be able to do so without the use of an interpreter. Crucially for the panel, that means that where an individual has chosen that route, the panel will need Welsh proficiency. Welsh speakers have had the right to ask for services in Welsh for years now, so assisted dying should be no different. That is why services in Welsh need to be on the face of the Bill. I wholeheartedly support the amendment and will vote for it if the right hon. Member chooses to press it.

Sojan Joseph: I will not talk for long, because most of my points have already been raised. I welcome the provisions in new schedule 2 on membership of the panel. I was concerned about all patients having access to a psychiatrist and a social worker, so the measures proposed are welcome and reassuring. My reservation, which other hon. Members have raised, is that it would be even better for people to have earlier access to the panel. I am also concerned about whether the panel would have the power to overturn the decisions taken by the two doctors and whether it might be influenced by them.

In addition, will the Health Minister clarify his response to amendment 1? He said that specifying one category of doctor, a registered psychiatrist, would create capacity issues. I hope that that will not be an issue when we have a psychiatrist on the panel. Otherwise, I welcome the proposals.

Rebecca Paul: First, I apologise: I have quite a lot to talk about.

Danny Kruger: On a point of order, Mrs Harris. I do not know whether this is appropriate, but was there a proposal to adjourn? I am conscious that my hon. Friend is about to make a very long speech.

The Chair: Yes, there was, but you cannot move the Adjournment while the hon. Lady is still speaking.

Rebecca Paul: I am happy to give way to my hon. Friend.

The Chair: Order. The Adjournment cannot be moved on an intervention.

Rebecca Paul: As long as I can make another speech, I am comfortable with stopping at this point and giving everyone a break from my voice.

Ordered, That the debate be now adjourned.—(Bambos Charalambous.)

7.16 pm

Adjourned till Wednesday 12 March at twenty-five minutes past Nine o'clock.

Written evidence reported to the House

TIAB 419 Nathaniel Dye MBE

TIAB 420 ADF UK

TIAB 421 Dr D. P. Whitehouse (further evidence on
BMA Consultants' Conference motion of 4 March)

TIAB 422 Royal College of Physicians of Edinburgh

TIAB 423 Catherine Eden

