PARLIAMENTARY DEBATES

HOUSE OF COMMONS
OFFICIAL REPORT
GENERAL COMMITTEES

Public Bill Committee

TERMINALLY ILL ADULTS (END OF LIFE) BILL

Twenty-seventh Sitting

Wednesday 19 March 2025

(Afternoon)

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Sunday 23 March 2025

The Committee consisted of the following Members:

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

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

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

† **attended the Committee**

Public Bill Committee

Wednesday 19 March 2025

(Afternoon)

[Peter Dowd *in the Chair*]

Terminally Ill Adults (End of Life) Bill

2 pm

The Chair: Will everyone ensure that all electronic devices are turned off or switched to silent mode? As people know, tea and coffee are not allowed in the Committee Room.

We now continue line-by-line consideration of the Bill. I remind Members, as I often do, that interventions should be short and raise points of clarification or questions; they should not be speeches in and of themselves. Members who wish to make a speech should bob, and continue to do so throughout the debate in which they wish to take part, until they are called. When Members say "you", they are referring to the Chair. "You" should not be used to refer to one another; the debate should be through the Chair.

Clause 23

No obligation to provide assistance etc

Amendment proposed (18 March): 480, in clause 23, page 15, line 3, leave out subsection (1) and insert—

"(1) No individual is under any duty (whether arising from any contract, statute or otherwise) to be involved, directly or indirectly, in the provision of assistance in accordance with this Act.

(1A) In particular, no individual is under any duty (whether arising from any contract, statute or otherwise) to—

(a) provide information about assisted dying;

(b) participate in an initial discussion;

(c) participate in the request and assessment process;

(d) supply, prescribe or administer an approved substance;

(e) be present at the time of administration of an approved substance; or

(f) dispense a prescription of an approved substance.

(1B) Nothing in subsections (1) or (1A) of this section shall affect any duty to—

(a) signpost someone to where they can obtain information about assisted dying (under section 4(5) or otherwise);

(b) perform acts of a clerical, secretarial, or ancillary nature; or

(c) perform any acts necessary to save the life of or to prevent grave injury to a person."

—(Danny Kruger.)

This amendment would expand the provision of Clause 23(1) to all individuals and clarify the activities in which they are not obliged to participate.

Question again proposed, That the amendment be made.

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

Amendment 483, in clause 23, page 15, line 5, after "assistance" insert

", or in any activity closely related to the provision of assistance,".

This amendment would widen the range of activities which medical practitioners and other healthcare providers are not under an obligation to provide to include activities closely related to the provision of assistance under the Act.

Amendment 484, in clause 23, page 15, line 8, after "Act" insert

", or in any activity closely related to the provision of assistance under this Act,".

Amendment 441, in clause 23, page 15, line 9, at end insert—

"(3) There is no obligation on any care home or hospice regulated by the Care Quality Commission or the Care Inspectorate Wales to permit the provision of assistance under this Act on their premises."

This amendment prevents there being any obligation on a care home or hospice which is regulated in England or Wales to permit the provision of assistance under the Act on their premises.

Amendment 481, in clause 23, page 15, line 9, at end insert—

"(3) Nothing in subsection (2)—

(a) prevents an employer who has chosen not to participate in the provision of assistance in accordance with this Act from prohibiting their employees from providing such assistance in the course of their employment with that employer, or

(b) prevents an employer from specifying occupational requirements in relation to the provision of assistance in accordance with this Act in accordance with Schedule 9 of the Equality Act when hiring employees."

This amendment ensures that employees cannot provide assisted dying against the wishes of their employers and that employers can still rely, in appropriate cases, on the occupational requirements of the Equality Act to either require employees to provide or not to provide assisted dying.

New clause 22—*No obligation for occupiers and operators of premises—*

"(1) Any individual, business, organisation, or association who occupies or operates premises has the right to refuse to permit the self-administration of an approved substance on their premises.

(2) Nothing in subsection (1) confers any right on anyone with an interest in the land but who is not occupying or operating those premises."

This new clause would mean that the owners or occupiers of premises — but not landlords not currently in occupation — are not obliged to permit the self-administration of approved substances on their premises.

New clause 23—*No detriment for care home or hospice not providing assistance—*

"(1) No regulated care home or hospice shall be subject to any detriment by a public authority as a result of not—

(a) providing assistance in accordance with this Act, or

(b) permitting such assistance to take place on their premises.

(2) No funding given by a public authority to a regulated care home or hospice can be conditional on that care home or hospice—

(a) providing assistance in accordance with this Act, or

(b) permitting such assistance to take place on their premises."

This new clause would mean that regulated care homes and hospices cannot be subject to any detriment for not providing or permitting assistance in accordance with this Act, and that their funding cannot be conditional on them providing or permitting such assistance.

Clause stand part.

Danny Kruger (East Wiltshire) (Con): I was just concluding my remarks on the amendment. I will quickly finish responding to the hon. Member for Spen Valley and others, who suggested that it would be improper to deny people living in a care home, hospice setting or other communal environment the right and opportunity to request assisted dying. I was suggesting that that right needs to be tempered by an acknowledgment that they do not live there alone, and that there are also rights, properly held, by the occupier of the premises, the individual's neighbours and others.

My concern is that, just as suicide itself is contagious, so the practice of assisted suicide will have social ramifications. We fully recognise that, if the Bill is passed, people will have the absolute right to request the service in their own home, but when someone is living among others, that right needs to be tempered by the consideration that the occupier should ultimately decide whether he or she is prepared to allow the practice to take place on his or her premises.

Some hon. Members suggested that, if an institution receives public funding, it would be appropriate for it to be obligated to deliver the service. I am concerned about the implication of that, which might be that institutions that did not wish to provide or facilitate assisted suicide but did receive public money, for instance care homes or hospices, would be at risk of losing that money—essentially being defunded—on the grounds of their conscientious objection to participating in assisted dying. I would be grateful if the hon. Member for Spen Valley or Ministers would confirm that it is not their intention to penalise bodies that do not deliver assisted dying by withdrawing public money.

On the impact on staff, I am grateful to the hon. Lady for acknowledging that we might need to tighten the Bill to ensure that it is clear that people will not be required to participate in any stage of the process of assisted dying, and not just in the actual provision of assistance towards the final act. Nevertheless, my concern is that if we do not give institutions the right to opt out of provision, there will be an exodus of staff who object to being involved in any way with, or working for an institution that facilitates, assisted dying, as has happened in other jurisdictions where assisted suicide is legal.

I point particularly to evidence we heard from Australia. We were told that, in consequence of assisted dying being legalised in Australian states, there was an exodus of workers from the healthcare system—nurses and others—and the social care system. It was therefore no coincidence when one of the Australian witnesses who supports assisted suicide declared breezily that, although there were significant objections among the care workforce to the introduction of assisted dying when the law was first debated, five years later there was overwhelming support for assisted dying among them. Well, that is no surprise, because all the objectors had left, and I am afraid that is what we will see here.

A comparison would be the exodus of care workers that we saw after the last Government mandated covid vaccination. Some 40,000 care workers left their jobs rather than accept compulsory vaccination. If they were prepared to do that on those grounds, I fear we might see a similar phenomenon if we mandate that institutions facilitate assisted dying.

Lewis Atkinson (Sunderland Central) (Lab): May I check that the hon. Member's understanding is the same as mine—that nothing in the Bill compels an organisation to participate in the way that he describes?

Danny Kruger: No, I am afraid I do not concede that. At the moment, it is not apparent from the Bill or the amendments that have been accepted that an organisation would be enabled to decline to facilitate the provision of assisted dying. No organisation will be compelled to do so, but if a resident were to request assisted dying in their care home, my understanding is that the care home would be obliged to facilitate it.

It might well not be the intention behind the Bill, because I know that the hon. Member for Spen Valley and Members who agree with her recognise the importance of a conscience exception; they have been very clear on that, and I am grateful to them. Nevertheless, my concern is that on human rights grounds, as we have heard from the Minister, the likelihood is that there would be a claim on behalf of an applicant against the institution they reside in that assisted suicide must be provided to them in that place. I am afraid the Bill at the moment does not give an adequate exemption to institutions.

Lewis Atkinson: Does the hon. Member accept the distinction that I made between an organisation choosing to provide assisted dying services and the instance he outlined of this being done in someone's home that happens to be a care home? They are entirely different points, and I fear that, particularly with regard to hospices, he is conflating the two.

Danny Kruger: I am conflating the two because they are conflated in reality. A care home where somebody lives is a residence, but it is also a community, a facility and a place where professionals work to support that individual. A clear demarcation between their living arrangements and the support they receive from the institution they live in does not exist in reality. That is why they are living there—because that distinction does not apply in their particular case. They require the support and help of the workers in the place where they live.

I am afraid it is not enough simply to say, "This is their home, and they should have exactly the same rights and freedoms as they would have if they were living alone in their own flat or house." We have to recognise the reality of the situation, which is that they are living in a community, and what happens in the community affects them all. That is the nature of communal living. This is not individualised healthcare in the way that the hon. Gentleman imagines it is, and that is fundamentally our point of difference. This is separate or adjacent to healthcare, and it is delivered, by definition, by somebody else. By virtue of the Bill, it would have a separate regulatory environment to other healthcare treatments. Of necessity, it should have an appropriate legal framework to protect other people who are impacted

[Danny Kruger]

by assisted death in a communal setting. That is my crucial point: if someone is living in a communal setting, what they do affects their neighbours.

Jake Richards (Rother Valley) (Lab): Does the hon. Gentleman appreciate that, although this is different from the healthcare services we currently have, we have a legal framework that deals with many of these conflicting issues as and when they arise in lots of different circumstances that are not completely adjacent to these?

Danny Kruger: I do not know what those might be, but I would be interested to hear. That might well be the case. I am afraid that no hard-and-fast rules can be clearly applied here; or, rather, we have to apply hard-and-fast rules in the knowledge of the grey areas, the exceptions and the situations in which we might feel that the law is unjust in particular cases. We have heard examples of that, such as the evidence about the lady in Australia cited earlier by the hon. Member for Spen Valley. I can well imagine the distress involved if someone suddenly finds themselves in an institution that does not permit an assisted death, but they want one and are in their last days.

The alternative, however, is a different blanket rule. If we were to have a blanket rule that we can do an assisted death anywhere—that is one situation—there would be significant knock-on effects. Serious moral injury would be suffered by other professionals and residents. I recognise that my amendment could lead to someone having to relocate if they want to have an assisted death—I am sorry for that—but I think that we have to draw the line in a way that makes most sense.

Kit Malthouse (North West Hampshire) (Con): It would be interesting, if my hon. Friend's amendments go through, to see the series of plebiscites taking place in care homes and communal situations across the country as to what the residents do and do not want, presumably by a majority. He asserted that there had been a mass exodus of healthcare workers when VAD came in, but I am struggling to find any evidence to support that claim. In fact, the evidence seems to say that that is not the case. Although there have been some resignations, that has largely been because of pay and conditions, as one might expect.

Danny Kruger: My right hon. Friend seems hung up on this suggestion that there needs to be a plebiscite or communal decision making—some kind of citizens' jury. I am not suggesting that for one moment. In fact, I am sure that I have said explicitly that what I want, and what the amendment would enable, is that the owner or occupier, who would probably be an individual or a board of directors, would decide what happens. If they are a decent, compassionate organisation, they might well consult residents—in fact, I would very much expect that to happen if they are doing their job properly—but I am talking about the importance of communal living; and the fact is that a communal living arrangement has leadership. The residents have signed terms and conditions, in a contract, under which they have agreed to abide by certain rules of the house. My suggestion is that if the charity, company or organisation that is managing a care home wants to stipulate that there shall be no provision of assisted dying in that care home, they should have the right to do so. I hope my right hon. Friend would acknowledge that that is consistent with English property rights.

On my right hon. Friend's second point, I am grateful to him and he might well be right. I am happy to consult my evidence pack, which I do not have at my fingertips, about the effect on the Australian workforce in consequence of the introduction of assisted dying. My memory is that we heard such evidence, or had it submitted to us in written form—his knowledge of the 500 submissions might be better than mine. Let us check and we will have it out, perhaps on social media; I know how much he enjoys those forums.

Question put, That the amendment be made.

The Committee divided: Ayes 4, Noes 17.

Division No. 62]

AYES

Kruger, Danny	Paul, Rebecca
Olney, Sarah	Shah, Naz

NOES

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

Question accordingly negatived.

Amendment proposed: 484, in clause 23, page 15, line 8, after "Act" insert

", or in any activity closely related to the provision of assistance under this Act,"—*(Danny Kruger.)*

Question put, That the amendment be made.

The Committee divided: Ayes 4, Noes 17.

Division No. 63]

AYES

Kruger, Danny	Paul, Rebecca
Olney, Sarah	Shah, Naz

NOES

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

Question accordingly negatived.

Amendment proposed: 441, in clause 23, page 15, line 9, at end insert—

"(3) There is no obligation on any care home or hospice regulated by the Care Quality Commission or the Care Inspectorate Wales to permit the provision of assistance under this Act on their premises."
—*(Danny Kruger.)*

This amendment prevents there being any obligation on a care home or hospice which is regulated in England or Wales to permit the provision of assistance under the Act on their premises.

Question put, That the amendment be made.

The Committee divided: Ayes 4, Noes 17.

Division No. 64]

AYES

Kruger, Danny	Paul, Rebecca
Olney, Sarah	Shah, Naz

NOES

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

Question accordingly negatived.

Amendment proposed: 481, in clause 23, page 15, line 9, at end insert—

"(3) Nothing in subsection (2)—

(a) prevents an employer who has chosen not to participate in the provision of assistance in accordance with this Act from prohibiting their employees from providing such assistance in the course of their employment with that employer, or

(b) prevents an employer from specifying occupational requirements in relation to the provision of assistance in accordance with this Act in accordance with Schedule 9 of the Equality Act when hiring employees."—*(Rebecca Paul.)*

This amendment ensures that employees cannot provide assisted dying against the wishes of their employers and that employers can still rely, in appropriate cases, on the occupational requirements of the Equality Act to either require employees to provide or not to provide assisted dying.

Question put, That the amendment be made.

The Committee divided: Ayes 4, Noes 17.

Division No. 65]

AYES

Kruger, Danny	Paul, Rebecca
Olney, Sarah	Shah, Naz

NOES

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

Question accordingly negatived.

Clause 23 ordered to stand part of the Bill.

Clause 24

CRIMINAL LIABILITY FOR PROVIDING ASSISTANCE

2.15 pm

Kim Leadbeater (Spen Valley) (Lab): I beg to move amendment 504, in clause 24, page 15, line 11, leave out from second "of" to end of line 12 and insert

"—

(a) providing assistance to a person to end their own life in accordance with this Act, or performing any other function under this Act in accordance with this Act, or

(b) assisting a person seeking to end their own life in accordance with this Act, in connection with the doing of anything under this Act.".

This amendment provides that it is not an offence to perform a function under the Bill, or to assist a person seeking to end their own life, in connection with the doing of anything under the Bill.

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

Amendment 505, in clause 24, page 15, leave out lines 22 and 23 and insert

"—

(a) providing assistance to a person to end their own life in accordance with the Terminally Ill Adults (End of Life) Act 2025, or performing any other function under that Act in accordance with that Act, or

(b) assisting a person seeking to end their own life in accordance with that Act, in connection with the doing of anything under that Act.".

This amendment ensures that it is not an offence under the Suicide Act 1961 to perform a function under the Bill, or to assist a person seeking to end their own life, in connection with the doing of anything under the Bill.

Clause stand part.

I remind Committee members that we expect four or five votes at about 2.50 pm. In that case, we will suspend for an hour, similarly to last night, and come back at 3.50 pm, but we will cross that bridge when we get to it.

Kim Leadbeater: These amendments relate to criminal liability under the Bill. They get to the heart of why the legislation is needed. Amendment 504 seeks to clarify the language of clause 24 and provide reassurance that it will not be considered an offence to perform a function under the provisions of the Bill or to assist a person seeking to end their own life in connection with anything done under the Bill. It will ensure that those acting within the law, and with compassion, to assist terminally ill individuals who wish to end their suffering and take control at the end of their life are protected under the law.

Amendment 505 ensures that the provisions of the Terminally Ill Adults (End of Life) Act 2025 will supersede the Suicide Act 1961, providing clarity that actions taken under the new Act will not be subject to the outdated legal framework established under the 1961 Act. That is a crucial step in modernising our laws to reflect the values of compassion, dignity and personal autonomy. These amendments bring us closer to a legal framework that is clear and safe.

Our Prime Minister, my right hon. and learned Friend the Member for Holborn and St Pancras (Keir Starmer), the former Director of Public Prosecutions, stated in relation to assisted dying, "The law must reflect the

[Kim Leadbeater]

changing moral landscape of society, and in cases such as this, where the individual's autonomy and suffering are at stake, our legal framework must offer clarity and compassion." During his tenure as DPP, Sir Keir also emphasised the importance of not criminalising individuals who act out of compassion, particularly in difficult and morally complex situations. He said, "The law must be clear, and it must ensure that those who act with the intention to relieve suffering are not penalised, as long as their actions are in accordance with the law." That sentiment is echoed in the amendments before us today, which ensure that those who assist individuals under the Bill are protected by law, offering clarity and reassurance to both the public and professionals who may be involved in such decisions.

Sir Max Hill, another former Director of Public Prosecutions, remarked in 2019, "The law around assisted dying is often unclear and creates a great deal of uncertainty for both individuals and healthcare professionals. What we need is a system that balances compassion with protection, ensuring that people who are at their most vulnerable are supported in a way that is both legal and ethical." Sir Max Hill's words emphasise the need for clear, compassionate guidance, which these amendments will provide. They will help to eliminate the legal uncertainty that can cause fear and hesitation in those who act in the best interests of individuals facing terminal illness.

The 2010 DPP policy clarified that assisting someone to end their life was not automatically criminal and that each case would be assessed on its individual facts. However, that has not changed the law and many people are still being failed by the law as it stands. These amendments create clarity and prevent ambiguity around what constitutes a criminal act versus an action legally protected by the new law.

I will finish with a very powerful testimony from Louise Shackleton from Scarborough. Louise accompanied her husband to Dignitas last December. I believe she was the first person to make that trip since Second Reading. Louise talks about the trip she made to Switzerland with her husband. She says:

"This is not an easy process as some against Assisted Dying might have you believe, might try and convince you. It is a robust and thorough almost an ordeal in itself. Then there is the cost, not just financially but mentally and physically as he had to be able to get to Zurich and someone had to assist him to do this…My husband did not deserve this to be his end nor did I deserve this to be his end, my last memory of him…I accompanied my husband to Switzerland, where we had 4 wonderful days together, my husband's mood had lifted, he was at peace, it was as if the weight of the world had been lifted from his shoulders. He was not scared, no anxiety, his emotional suffering had ceased. You cannot imagine unless you see and feel this he was looking forward to his peaceful death, looking forward to leaving his pain, suffering…At the end, my husband was able to die on his own terms, pain-free and peaceful, held in my arms as his heart gently slowed and finally stopped, granting him the dignified and serene farewell that he had wished for. But where was I? alone in a strange country alone, scared, bereft, organising an Uber to take me away from the…Dignitas House, I was vulnerable and in utter shock, now having to leave my dead husband alone, leave his body to be cared for by people I had never met…Due to our draconian laws my husband had to be in a foreign country, had to be cremated to be brought back home. No funeral that he would have chosen, no mourners, no ceremony, cremated with no Reverend to pray for him, returned to me in a cardboard box. The pain is excruciating beyond any other loss I have experienced".

She then says:

"I have been arrested and spent just under three hours being interviewed by two CID officers. Four days after my husband left my world there I was stuck in a Police station being cautioned, questioned, having to relive my trauma, for my crime, a crime made by love, a crime made by adoration, a crime of compassion and respect of my husband's last wish."

She now faces a prolonged police investigation. She tells us,

"My husband was the first British person to go to Dignitas after parliament debated on Friday 29th Of November 2024. You have the power, the power is yours to be human, to follow Gods wish, to 'suffer' choices that other people may make even if its uncomfortable for you. Palliative care I hear you say, My Husband did not want palliative care…Please give others the gift of dignity and a good death in their homes…You have the power to do something amazing, give people the choice."

I commend these amendments, which will help many people. Sadly, it is too late for Louise, but they will help many other families who will potentially go through what she has been through.

Rebecca Paul (Reigate) (Con): I rise to speak briefly on clause stand part. As I noted a few weeks back—it feels a long time ago—when we debated amendment 82, the clause leaves the law in a strange position. I hope that we will now have the opportunity to explore that and make sure that we are comfortable with the position and have identified whether any changes are needed.

Section 2(1) of the Suicide Act 1961 criminalises both assisting and encouraging suicide:

"A person ('D') commits an offence if—

(a) D does an act capable of encouraging or assisting the suicide or attempted suicide of another person, and

(b) D's act was intended to encourage or assist suicide or an attempt at suicide."

It is a single offence, but can be committed in two ways: either through assistance or through encouragement.

Clause 24(3), both as drafted and as amended by amendment 505, would make an exception from criminal liability under the Suicide Act, but in respect only of assistance, not of encouragement. It would cover:

"(a) providing assistance to a person to end their own life in accordance with the Terminally Ill Adults (End of Life) Act 2025, or performing any other function under that Act in accordance with that Act, or

(b) assisting a person seeking to end their own life in accordance with that Act, in connection with the doing of anything under that Act."

In other words, it is strictly limited to assisting suicide. It only covers the actions in the Bill around conducting the preliminary discussion, assessing the applicant, giving the applicant the approved substance and so on. What happens to the other half of section 2 of the Suicide Act: the offence of encouraging suicide? I will not rehash the debates that we had over amendment 82, but I must point out that as that amendment was rejected, the law does not dovetail. Encouragement would still be very much an offence under the Suicide Act, as it has not been excepted under the Bill.

Because my amendment was not agreed to, we will have the absurd situation in which somebody can commit the crime of actively encouraging someone to take their own life, yet that will not be looked for or taken into account when assessing someone's eligibility for an assisted death. On the flipside, there is a very real risk

for families and friends of loved ones who could inadvertently overstep the mark and move from support of a loved one to encouragement. It does not take much imagination to realise that that could lead to accusations and potentially even to prosecution if the law is not sorted and clarified at this stage.

We already know how difficult it has been for family members who want to accompany loved ones to Dignitas but fear that they could face prosecution; the hon. Member for Spen Valley has made that point so eloquently. No one wants that, so it is important that we ensure that the Bill does not create a similar situation in which someone could be unfairly prosecuted for encouragement, which is still very much a crime under the Suicide Act.

2.30 pm

Let us make the law really clear on the point so that we know which behaviours are criminal and which are not. One cause of the lack of clarity is the word "encouragement". What is its meaning? What types of activity would a court consider to be encouragement under the Suicide Act? I know that we started this debate a number of weeks ago, so I look forward to the Minister clarifying the point and setting out whether she is happy with the Bill as drafted.

Under clause 26, coercing or pressuring a person into an assisted death is a criminal offence, and rightly so. There has, however, been much debate on whether undue influence and encouragement are also covered. The Minister advised previously that undue influence is covered, and I seem to recall that encouragement could be covered as well. If that is correct, we would have the sloppy situation in which encouragement could be a criminal offence both under the Bill and under the Suicide Act. It would be really helpful if the Minister set out the position clearly on the point, to make sure that we do not inadvertently end up in that situation. I imagine that best practice is to have only one criminal liability in one Act or the other, if it is appropriate at all.

Danny Kruger: It is an honour to follow my hon. Friend the Member for Reigate; I very much agree with the points that she made, and I hope that Ministers will respond. I will try not to repeat her arguments.

The hon. Member for Spen Valley says that clause 24 is, in a sense, the heart of the Bill. I agree. Without the clause the Bill would be ineffective, because the service that we are proposing to legalise would be illegal. We have heard many objections to the term "assisted suicide", but the necessity of the clause exposes the fact that what is being legalised, at least in part, is assisted suicide. Calling it assisted suicide is therefore not improper; it is simply using the correct terminology, as I believe we should in this place. That is particularly important because the use of the euphemism "assisted dying" masks what this is really about and what the Bill would actually legalise: that somebody could help somebody else to commit suicide.

It is no surprise that the euphemism is deployed, because support for what is called assisted dying is driven in part by a failure to realise what it actually is and what the words mean. I cite a 2024 Nuffield Council on Bioethics survey of the public, which found that 39% of people think that assisted dying means withdrawing life support, 19% think that it means providing people who are dying with drugs that relieve symptoms of pain or suffering, and 13% think that it means providing hospice care, all of which is legal currently and is good medical practice.

Lewis Atkinson: The hon. Gentleman says that he is clear that those actions are assisting suicide and that he thinks that they are illegal. Is it right that members of the public, in the instance to which my hon. Friend the Member for Spen Valley referred, be investigated by the police on their return from trips to Switzerland?

Danny Kruger: Let me come to the question of investigation by the police in due course, but I am not sure that the hon. Gentleman heard me clearly. I was not talking about offences that I think are rightly criminal; I was talking about offences that are not offences at all. Providing hospice care, helping people to relieve symptoms of pain or suffering and withdrawing life support are all perfectly permitted and legal in our system. The issue is that a significant proportion of the public think that those activities are what assisted dying entails. I do, however, recognise the point and the power of the testimony recited by the hon. Member for Spen Valley, to which I will come on in due course.

I understand that in order to make the Bill effective, an exception must be made to section 2 of the Suicide Act. Section 1 says that someone is allowed to commit suicide; section 2 says that one cannot help somebody else to do so. I agree that such an exception is necessary if we are to pass the Bill, but I cannot follow why clause 24(1) is needed. I will be grateful if the hon. Member for Spen Valley or the Minister can explain which other offences would necessarily be committed by a doctor properly carrying out his or her functions under the Bill. What other offences might be caught that require clause 24(1)?

Clause 18 will forbid a doctor from engaging in euthanasia. One criminal law from which an exemption is not necessary is the law on murder, yet ostensibly subsection (1) has no such limitation. I would be grateful for the Minister's confirmation that subsection (1) will not afford a defence when the charge is murder. I presume that that is not the intention.

What about manslaughter, and particularly gross negligence manslaughter? Under the Bill, a pharmacist performing the function of prescribing or dispensing the legal drugs would be, to use the wording of amendment 504, "performing" a "function under this Act". If a pharmacist makes a grossly negligent mistake and mislabels a drug, which is then sent to another patient who takes it and dies, that would quite clearly be gross negligence manslaughter. Can the Minister explain why clause 24(1), as amended by amendment 504, would not allow someone to benefit from an immunity in respect of gross negligence manslaughter? To be clear, I agree that if the pharmacist intentionally mislabelled the drug, he could not be described as

"performing any other function under this Act",

so he would not have that defence. However, in a case where, in good faith, he had made a fatal and grossly negligent mistake, surely he would have been performing such a function, albeit performing it very badly.

Can the Minister clearly set out the reasoning to explain why there is no chance of such a defence under the clause? Of course the hon. Member for Spen Valley does not intend to exempt from criminal liability a

[Danny Kruger]

pharmacist acting in that grossly negligent way, but I am trying to make sense of the drafting of the amendment. If there is any criminal offence, other than in the Suicide Act, that requires an exemption, it would be best to say so clearly in the Bill rather than relying on a catch-all term, as subsection (1) does.

I concur with the points made by my hon. Friend the Member for Reigate and will not repeat them, but I do find it interesting that the hon. Member for Spen Valley has chosen to retain the offence of assisting and encouraging suicide. This is because two arguments made by proponents of the Bill lead to the logical conclusion that the offence should either be repealed entirely or limited to self-conduct, as is the case in Switzerland. Let us look at the two arguments in turn.

The first argument relates to autonomy. If an autonomous individual with capacity decides to end their own life and requests the assistance of another person, why should that other person be criminalised? After all, that person is simply helping another person to do something to their own body that the law has not prohibited since 1961, so surely it is a violation of autonomy to criminalise such conduct of assisting in suicide.

Lord Mance, a former justice of the Supreme Court, put the matter as follows on Second Reading of the Meacher Bill in the other place:

> "Suicide is decriminalised, yet assisting suicide remains criminal—probably a unique exception to the principle that you can only be an accomplice to an act that is itself criminal."

It is bizarre that the act is not itself criminal but being an accomplice to it is. Lord Mance went on to say:

> "If a person may choose freely to commit suicide, what justifies a refusal to allow them to obtain willing assistance?"—[*Official Report, House of Lords,* 22 October 2021; Vol. 815, c. 408.]

I believe in the value of a prohibition on assistance, but the logic of the argument from autonomy—that someone should be allowed to request assistance to help them to die—surely obviates the distinction. I do not see why we have kept section 2 at all, and I would be interested in hearing from the supporters of the Bill what the limiting principle is. Why do they think assisted suicide should remain a crime, despite its being a limitation on autonomy, outside the scheme created by the Bill? Why are we simply creating a scheme within the Bill?

The second argument given, which I think relates to the intervention from the hon. Member for Sunderland Central and to the point made by the hon. Member for Spen Valley, is based on the fact that the current law requires people to travel to Switzerland. The argument against the current system comes in three forms. One stresses the toll that it places on families to know that the people who assist have committed a criminal offence and could be investigated by the police, even though the chances of prosecution are remote. I fully recognise and share all the concerns among Members about the terrible distress faced by people who may in any way have assisted their loved one to take their own life.

The second objection to the status quo makes the point about the unfairness that the situation creates. The hon. Member for Liverpool Wavertree (Paula Barker) said on Second Reading:

> "I do not want choice to be available only to those who can afford to pay. That is not just or equitable."—[*Official Report*, 29 November 2024; Vol. 797, c. 1073.]

The suggestion is that to have to pay to go to Switzerland is a violation of equality.

The third is a constitutional argument. It is said that it is constitutionally improper for the Director of Public Prosecutions to have effectively decriminalised assisted suicide for people who travel to Switzerland. But the point I am trying to make is that under the Bill, anyone helping their relative to travel to Switzerland, or any other country, would still be committing an offence under section 2 of the Suicide Act.

Research from My Death, My Decision, a campaign group pushing for a wider Bill than the current one—it supports the Bill but clearly wants it to go further—has found that 50% of cases going to Dignitas would not be eligible under the Bill. It helps to make my point, which is that I am afraid that if the Bill were passed we would still have stories like the very moving testimony read out by the hon. Member for Spen Valley. In fact, as my hon. Friend the Member for Reigate said, there is a significant likelihood that there would be more prosecutions. If the Bill were enacted, the conclusion of the Crown Prosecution Service and the police might well be that, given the existence of an assisted dying regime within the UK, assisting one's relative to go to Switzerland should be subject to a greater likelihood of prosecution. That is a legitimate concern.

Tom Gordon (Harrogate and Knaresborough) (LD): The point that the hon. Gentleman is making is actually one that I made yesterday. I appreciate that we are on entirely different sides of the debate, but that is exactly why I was talking about ensuring wider eligibility—the point he makes in relation to My Death, My Decision—and ensuring the provision of assistance for people who might have illnesses such as motor neurone disease. We have had to put a cut-off somewhere, and some people fall outside it, but does he accept that fundamentally this is about making sure that there are safeguards? That is the key point: that we should ensure safeguards. What the hon. Gentleman is talking about is exactly that.

Danny Kruger: I am grateful. With great respect to other members of the Committee, I think the hon. Gentleman is the most honest advocate of assisted dying among us, because he genuinely recognises that autonomy demands the widest possible range of eligibility. It might be that other Members feel that we have the balance exactly right. I recognise the force of his argument that if we are going to introduce a new human right, it is very difficult to circumscribe its boundaries. He himself thinks that there should be some boundaries: he proposed an amendment that specified 12 months, and he thinks that only certain people should be able to ask someone else to perform assisted death to them. Nevertheless, he is acknowledging that if we believe in autonomy, the Bill would not satisfy some people.

I think it would be intellectually coherent and more logical for proponents of the Bill to want to repeal section 2 of the Suicide Act, and I do not understand why they are not doing so. We could certainly continue to insist on prohibitions against any form of coercion, persuasion or inducement to take one's own life, but if

somebody is clearly in their right mind and wants to receive assistance to kill themselves, that is the principle of the Bill. It would be neater if we amended the Suicide Act accordingly.

The fact that proponents do not want to do so suggests that they see some value in the law and that they consider that that value trumps concerns about autonomy and the impact of the law on family members of someone who wishes to travel to Switzerland to end their life. I agree that there are such principles—namely, the intrinsic value of life and the protection of the vulnerable—but I do not see why proponents of the Bill consider that such principles trump autonomy when it comes to terminally ill adults in England.

The Minister of State, Ministry of Justice (Sarah Sackman): It is a pleasure to serve under your chairship, Mr Dowd. My remarks, as ever, will focus on the legal and practical impact of the amendments to assist Members in undertaking line-by-line scrutiny. In exercising our duties to ensure that legislation that is passed is legally robust and workable, the Government have worked closely with my hon. Friend the Member for Spen Valley to reflect her intent.

Clause 24, as amended by amendments 504 and 505, will mean that individuals who assist a person to end their life in accordance with the terms of the Bill are not subject to criminal prosecution. Currently, it is a criminal offence under section 2 of the Suicide Act 1961 for a person to do an act that is

"capable of encouraging or assisting the suicide or attempted suicide of another person"

and intended

"to encourage or assist suicide or an attempt at suicide."

That offence attracts a maximum penalty of 14 years' imprisonment. Amendment 504 would amend clause 24(1) to ensure that a person is not guilty of an offence—*[Interruption.]*

The Chair: Order.

2.46 pm

Sitting suspended for Divisions in the House.

4.10 pm

On resuming—

Sarah Sackman: I was introducing amendment 504, which amends clause 24(1) to ensure that a person is not guilty of an offence by virtue of providing assistance in accordance with, or performing a function under, the Bill—for example, by undertaking the first or second assessment or providing the approved substance. The effect of the amendment is to ensure that a person is not guilty of an offence by virtue of assisting a person seeking to end their own life in accordance with the Bill. The phrase "in accordance with" the Bill is key. For example, where someone accompanies a person to the appointment at which they will self-administer the substance, the amendment would carve out any criminal liability for the accompanying person.

As originally drafted, the wording would have limited the protection offered by subsection (1) to the far narrower situation of the medical professionals providing assistance under clause 18. The amendment will give effect to the policy intent of the hon. Member for Spen Valley of applying that protection to all those who provide assistance in accordance with, or by performing a function under, the Bill. Subsection (2) clarifies that the clause does not override other ways in which a court may find that a person is not guilty of an offence.

Clause 24(3) inserts proposed new section 2AA into the Suicide Act 1961. As amended by amendment 505, that new section ensures that it is not an offence under the Suicide Act to perform a function under the Bill, or to assist a person seeking to end their own life by doing anything under the Bill. That is for the same reasons that I set out in relation to subsection (1). The new section also provides a defence to the offence of encouraging or assisting suicide, where a person reasonably believes that they were acting in accordance with the Bill, and that they took all reasonable precautions and exercised all due diligence to avoid committing the offence.

Taken as a package, the effect of these amendments is to make the Bill legally workable. To do that, it is necessary to ensure that those who assist a person to use the lawful route are not then subject to criminal liability for doing so. Clause 24 clause, taken together with amendments 504 and 505, gives effect to that.

Let me address some of the issues raised by Opposition Members. There was a question as to whether there is any overlap between offences under the Bill—we will come to some of those offences in due course with clauses 26 and 27—and offences that remain on the statute book under the Suicide Act. The short answer to the question from the hon. Member for Reigate, although I know she has written to my Department, and I will ensure that she receives a full written answer, is that it would remain an offence under the Suicide Act 1961 to encourage suicide, including an assisted death under this Bill.

To the extent that any overlapping offences remain, that is not an unusual approach to drafting in the criminal law. However, the effect of the clause is that it would remain an offence under the 1961 Act to encourage someone to commit suicide. Where a person's "encouragement"—the hon. Member focused on that term—is such that it amounts to what the courts would understand to be pressure or coercion, that could be an offence under clause 26, which we will come to. As I said, it is not unusual to have a degree of overlap in criminal offences. Again, what someone is charged and prosecuted with falls to the prosecutor, depending on the specific circumstances of the case and what would be most appropriate in that scenario.

I also want to address the scenario that the hon. Member for East Wiltshire posited, about whether a pharmacist who acted in a way that amounted to gross negligence manslaughter would benefit from immunity under clause 24(1) as amended. Again, with the important caveat that it will depend on the particular facts of the case, the offence of gross negligence manslaughter is committed where a death is the result of gross negligence in what would otherwise be a lawful act or omission on the part of the defendant, and where the defendant owes a duty of care to the victim—there are a number of actors within the Bill's process who owe a duty of care to the person applying for assisted dying.

[Sarah Sackman]

Let us assume for a moment that, in the hon. Member's scenario, we do have gross negligence manslaughter on the particular facts; in those circumstances, the Government are content that the pharmacist could not be properly said to be performing a function under the Bill, or in accordance with the Bill, so clause 24(1)—the carve-out from criminal liability—would not apply. I think that that covers most of the questions that were posited earlier.

Danny Kruger: It may well be that the Minister has clarified the case sufficiently, but will she explain something for my sake? She is suggesting that the pharmacist inadvertently but negligently caused the death of a patient, having performed the duties under the Bill and believing that they were doing so. Surely, they were performing duties under the Bill, so they would potentially be captured by the carve-out.

Sarah Sackman: Again, it would depend on the actual facts. However, if they were attempting to perform duties under the Bill, it is highly unlikely that, in circumstances where the facts establish and meet the threshold of gross negligence manslaughter, they could be said to have carried out those duties in accordance with the Bill. They might have been carrying out duties that they thought were what the Bill prescribed, but if they have done that in such a way that it amounts to gross negligence manslaughter, then clause 24(1) would not apply.

The hon. Gentleman makes the point about what the pharmacist in that scenario believes they are doing; that belief has to be reasonable, and that is a test that our courts are well used to applying. That is why the amendments introduce the belief that someone is acting in accordance with the Bill. It is not enough that they think they are doing it; it has to be a reasonable belief. That is an objective standard.

Rebecca Paul: I thank the Minister for those helpful clarifications. Was any consideration given to also exempting encouragement as an offence under the Suicide Act? I am interested in why it was not exempted in the same way as assistance, particularly given that if it did fall within coercion and pressure—based on what the Minister said—it would get picked up as a criminal offence anyway under the Bill. I appreciate that the Minister will write to me on some of this, but the issue comes back to what is encouragement. As the hon. Member for Spen Valley set out—

The Chair: Order. As I have said time after time, if it is a question of receiving clarification, Members should keep their comments short, rather than expanding on them.

Rebecca Paul: My apologies, Mr Dowd, but it is a technical point. I think the Minister understands what I am asking.

Sarah Sackman: Helpfully, the hon. Member has also set out her questions fully and precisely in a letter to me, so I think I know what she is asking and I will try and answer it as best I can. I reiterate, as I and the Minister for Care have said throughout, that the policy choices have been for the promoter—the Government remain neutral. The offence of encouraging or assisting suicide or attempted suicide in section 2 of the Suicide Act is well established. Encouraging someone to go through the assisted dying process under the Bill with the intention of encouraging suicide or an attempt at suicide would therefore remain a criminal offence under section 2 of the Suicide Act. That is what I made clear earlier.

What we are talking about will always depend on the particular circumstances of the case. It is the Government's view that in a scenario—I think this is what the hon. Member for Reigate is getting at—where a family member or friend simply suggests to a person with a terminal condition that the option of assisted death under the Bill is something they may wish to consider, and nothing more, it is unlikely—dare I say, inconceivable—that that would amount to an offence under the 1961 Act.

However, if someone encourages a person in a more tangible way, such as encouraging or pressuring them to make the first declaration, that could well amount to an offence under the 1961 Act. Where that encouragement crosses the threshold into what, interpreted in line with their natural meaning, the courts would understand as pressure or coercion, that could amount to an offence under clause 26 of the Bill, which we will come to in due course. I hope that that addresses the hon. Lady's question. I will set that out to her in writing, and she is welcome to write back if there is any ambiguity.

I hope that that assists the Committee. I am going to sit down before anybody else intervenes.

The Chair: May I make an observation? I understand where the hon. Member for Reigate is coming from, but if letters have gone back and forth to the Department and other Committee members are not privy to what they say, the debate gets a little abstract. That is all I am trying to get to—we should not get too abstract, so that everybody knows what is being said.

Rebecca Paul: I appreciate that, Mr Dowd, which is why I was elaborating—I wanted to make sure that everyone understood the nature of the question without having seen the letter. In order to summarise, following your instruction, I refer to the letter.

Kim Leadbeater: I have nothing further to add.

Amendment 504 agreed to.

Amendment made: 505, in clause 24, page 15, leave out lines 22 and 23 and insert

"—

(a) providing assistance to a person to end their own life in accordance with the Terminally Ill Adults (End of Life) Act 2025, or performing any other function under that Act in accordance with that Act, or

(b) assisting a person seeking to end their own life in accordance with that Act, in connection with the doing of anything under that Act.".—*(Kim Leadbeater.)*

This amendment ensures that it is not an offence under the Suicide Act 1961 to perform a function under the Bill, or to assist a person seeking to end their own life, in connection with the doing of anything under the Bill.

Clause 24, as amended, ordered to stand part of the Bill.

Clause 25

CIVIL LIABILITY FOR PROVIDING ASSISTANCE

Kim Leadbeater: I beg to move amendment 501, in clause 25, page 15, line 31, leave out subsection (1) and insert—

"(1) The doing of any of the following does not, of itself, give rise to any civil liability—

(a) providing assistance to a person to end their own life in accordance with this Act;

(b) performing any other function under this Act in accordance with this Act;

(c) assisting a person seeking to end their own life in accordance with this Act, in connection with the doing of anything under this Act.

(1A) Subsection (1) does not apply—

(a) in relation to an act done dishonestly, or in some other way done otherwise than in good faith, or

(b) to any liability in tort arising from a breach of a duty of care owed to a person.".

This amendment ensures that the exclusion from civil liability applies in relation to persons performing functions under the Bill, and persons assisting a person seeking to end their own life, in connection with the doing of things under the Bill. It also excepts, from the exclusion from civil liability, things done dishonestly or not in good faith, and any liability arising out of negligence.

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

Amendment 502, in clause 25, page 15, line 34, after "life" insert

", or to attempt to do so,".

This amendment and amendment 503 are consequential on amendment 501.

Amendment 503, Clause 25, page 15, line 36, leave out subsection (3).

See the statement for amendment 502.

Clause stand part.

Kim Leadbeater: The amendments ensure that the exclusion from civil liability applies in relation to persons performing functions under the Bill and persons assisting a person seeking to end their own life in connection with the doing of things under the Bill. Importantly, they also rightly exempt from the exclusion from civil liability things done dishonestly or not in good faith, and any liability arising from negligence.

Proposed new subsection (1) in amendment 501 makes it clear that anyone providing assistance to a person to end their own life in accordance with the Bill will not face civil liability simply for doing so. That is crucial in offering clarity and confidence for healthcare professionals, family members or others who might otherwise hesitate due to fear of being sued for assisting a loved one or patient who wishes to end their life as a result of their terminal illness.

However, although we are providing protection, amendment 501 does not allow for unfettered actions without any accountability. Proposed new subsection (1A) ensures that any actions that are dishonest or done in bad faith are not protected from civil liability. Additionally, it states that breaches of a duty of care, such as negligence, are also not exempt from liability. This provision is a critical safeguard. It ensures that, although we provide legal protection for those acting with compassion and integrity, we also prevent exploitation or irresponsible actions, by making it clear that there is no immunity for actions that are dishonest or negligent. That strikes the right balance between compassionate assistance and legal accountability.

The amendment particularly reassures doctors, nurses, and healthcare workers—those who are most likely to be involved in the process. Often, they are deeply committed to palliative care and to supporting patients through their end of life journey, and the amendment ensures that they will not face legal risk if they provide assistance to eligible individuals under the Bill.

Danny Kruger: I rise to speak to clause 25 as a whole. First, though, I welcome the amendments tabled by the hon. Member for Spen Valley, because I recognise that she is attempting to fix a problem with the Bill.

However, I am afraid that my objection remains: the fact is that no other assisted suicide law in the world—including in common law jurisdictions similar to our own, such as Australia or New Zealand—has such a clause. There can be no justification for it. If, in the course of providing assistance under this Bill, a doctor commits a civil wrong, they ought to be liable for it in the usual way.

I am glad the hon. Lady has realised that a total exclusion of civil liability is not justifiable, but her change does not go far enough. Her amendments would preserve civil liability where an act was done dishonestly—not in good faith—or for liability in tort, based on the breach of a duty of care, or in other words the tort of negligence. However, it is worth noting that that still excludes civil liability in other respects, and we should ask whether that is justifiable.

First, the clause would still exclude civil liability under a contract, so a patient who has received improper care in breach of contract would not fall within either of the exceptions of proposed new subsection (1A). I take the point that, in the case of negligent care, there would often be a concurrent liability under the tort of negligence, and that that is preserved by new subsection (1A)(b), but that is not the case for other forms of contractual arrangements.

That might be particularly relevant in the situation of subcontracting. An example would be where an outsourcing company is tasked with transporting the lethal substance. Given the risks involved, the contract specifies strict rules that must be complied with, but the company does not comply with those rules. Under clause 25, even as amended, my concern is that they could not be sued for that breach of contract. What is the justification for excluding civil liability in contracts?

Secondly, there is the tort of trespass to the person, which is commonly relevant to medical practice, as it is under such torts that cases where there was no consent or capacity are handled. Those torts can be committed recklessly, but recklessness is not the same as bad faith or dishonesty, so liability could not be established under new subsection (1A)(a). Such torts are also different from negligence—they do not involve a duty of care—so they would not be covered by new subsection (1A)(b). I appreciate that, in many cases, liability could also be established under the tort of negligence, but that would not be the case in all cases. So I ask again: what is the justification for this exclusion?

[Danny Kruger]

Finally, and most concerning, we were told in previous debates that if it turned out that the criteria for an assisted death were not met, one could always apply for an injunction. Leaving aside the practical and financial obstacles involved in seeking an injunction at the last minute, which we have discussed before, my concern is that a private law injunction requires that a civil wrong either has been committed or is about to be committed. However, in a case where the doctors consider, in good faith and without negligence, that the criteria have been met, but the family has new evidence to show that that is not the case, the effect of clause 25, even as amended, would be that no civil wrong has been, or would be, committed in that instance, so the test for a private law injunction would not be met.

I might be wrong, so I would be interested to hear whether the Minister or the hon. Member for Spen Valley disagree with that analysis. I would be grateful if they could point out how the private law test for an interim injunction is met in such an instance.

All this could be much simpler if clause 25 were left out of the Bill entirely. Australia and New Zealand do not have such a clause or a civil liability exemption for practitioners of assisted suicide, and I am not aware of that having caused problems for practitioners, so I would be interested to understand why we need such a measure here.

4.30 pm

I understand that Members might be concerned about vexatious litigation but, first, if such claims are meritless there is no need for this provision, as the courts already have the power to deal with vexatious litigation. Secondly, the clause, with or without the amendments, will not be enough to stop vexatious litigation if it occurs. The strongest protection would be to retain the role of the High Court judge. In that way, the fact that the criteria have been met has been established by a court, and that makes it very unlikely that another court would want to reopen the matter. We have not done that, and we are left with this civil liability exemption, which remains too wide. I welcome the amendments in the name of the hon. Member for Spen Valley, but they do not go far enough. I believe the whole clause is unnecessary and should be removed.

Jake Richards: I welcome the amendments tabled by my hon. Friend the Member for Spen Valley. As I think she accepts, given that she tabled the amendments, there is an oddity with the Bill as drafted that has to be fixed, and I think the amendments would do that.

I appreciate that there is some force to the argument of the hon. Member for East Wiltshire. I would be interested to hear what the Minister says, but it seems to me that there is a balancing act between ensuring that medical practitioners and clinicians are working in an environment in which they do not constantly feel the heat of a lawyer's breath on their neck, and ensuring protections. There is some force to the argument for removing the clause altogether, but on balance I see more force in the argument that we should have more clarity.

I want to raise some more issues that need to be considered in the light of the provision for aspects of civil liability in this process. That is why last night I supported the amendment in the name of my hon. Friend the Member for Ipswich, which was not passed, relating to guidance for doctors in certain circumstances during this process. I raise those points about the standard of care and the duty that doctors and clinicians will be working to throughout the process for the record, and so that the Government and my hon. Friend the Member for Spen Valley can take them forward. I raise those questions not because they are unanswerable—I think they are answerable—but because we need to work out exactly what we are asking our doctors to work to, and what form that guidance comes in. Does it need to be legitimised by Parliament, or can it be undertaken by a Minister?

I do not think I need to expand greatly on the point, but we can all imagine circumstances in which clinicians are compromised in their view of the duty of care that they have to the patient. When this process begins in this jurisdiction, it needs to be clear what that is.

The Minister for Care (Stephen Kinnock): It is a pleasure to serve under your chairship, Mr Dowd. Well done for arriving on time, by the way.

These amendments aim to ensure that, if passed, this legislation will be legally and operationally workable. I will offer a technical, factual explanation and rationale for them. Amendments 501, 502 and 503 replace clause 25(1) and instead provide that the provision of assistance in accordance with the Bill will, of itself, not give rise to civil liabilities in certain circumstances. Those circumstances are where an individual provides assistance in accordance with the Bill, where an individual performs any other function under the Bill in accordance with the Bill, and where an individual assists a person seeking to end their life under the Bill, in connection with the doing of anything under the Bill. Proposed new subsection (1A) would create an exception to the exclusion of civil liabilities, providing that civil liabilities can arise in cases when an act is performed dishonestly or otherwise than in good faith, as well as in cases of negligence. Without this amendment, there is the possibility that clause 25(1) could provide blanket immunity to a person from all civil liabilities, even when they may have been negligent in their actions in providing assistance in accordance with the provisions in the Bill.

Kim Leadbeater: I will speak briefly on this issue. An important point was made by my hon. Friend the Member for Rother Valley about the protections that clause 25 and these amendments provide for medical practitioners. I think the clause strikes the right balance, but it is important to remove the blanket immunity. My hon. Friend referred to codes of practice and codes of conduct. We have talked a lot about good medical practice from the General Medical Council, and we have a clause in the Bill on codes of practice. I feel confident in the clause, but I am still having regular meetings with officials about the legal implications of the Bill. I will continue those conversations, but I am happy that the clause as it stands serves the correct purpose.

Kit Malthouse: Will the hon. Lady respond to the point about injunctions? The Minister might want to respond to this as well. My understanding is that in order to obtain an injunction, someone does not have

to establish that there is either a civil wrong or a criminal offence. They have to establish that there is a serious matter to be adjudicated, and that there is a strong likelihood of harm taking place. In those circumstances, a court would consider granting an interim injunction, subject then to a further hearing, ex parte or otherwise. The idea that some kind of civil tort needs to be established is not actually correct in seeking an injunction.

Kim Leadbeater: That would be my understanding as well, but I am not a lawyer. Fortunately, a lawyer just tried to intervene on me, so he might want to step in.

Jake Richards: My intervention is on something completely different. I have been reminded that in Australia, there is a specific clause that relates to the provision in this amendment almost word for word, so I think the hon. Member for East Wiltshire may have been incorrect in his comments.

Kim Leadbeater: I thank my hon. Friend for that. Unless the Minister has anything to add on injunctions—

The Chair: Order. Can the Committee address all remarks to me, please? I have said this time after time. This is not a dialogue or a chit-chat across the room.

Kim Leadbeater: Thank you, Chair.

Sarah Sackman: I will address the point about injunctions, which we have touched on at a number of junctures in our debate. In terms of applying for an interim injunction in a civil case, a very well-established test is the American Cyanamid test, which all the lawyers in the room would have learned at law school. The first of those tests is, "Is there a serious issue to be tried?" Someone does not have to establish to the civil standard—

The Chair: Order. Can we get the order of debate right? Members may make a speech for as long as they want, on the issues they want. They may intervene to get clarity from another Member, but that has to be short and sweet. There is nothing to stop a Member from making another speech, even if they have spoken before. I exhort Members, if they want clarity, to make a speech separately, unless it is a very short intervention. If it is going to be a long intervention, they may well want to make another de facto speech and get clarity through that. They are entitled to stand up as much as they want. I am not encouraging Members to do that, but that is the gist. If the Minister wants to stand up again and clarify the point in its own speech, that is fine.

Kim Leadbeater: Thank you, Chair, and apologies. I thank the Minister for the intervention and I think she did make the point that needed to be made.

The Chair: I hope my remarks were of some help. I might repeat them again in due course.

Amendment 501 agreed to.

Amendments made: 502, in clause 25, page 15, line 34, after "life" insert

", or to attempt to do so,".

This amendment and amendment 503 are consequential on amendment 501.

Amendment 503, in clause 25, page 15, line 36, leave out subsection (3).—*(Kim Leadbeater.)*

See the statement for amendment 502.

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

The Committee divided: Ayes 17, Noes 5.

Division No. 66]

AYES

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

NOES

Francis, Daniel	Shah, Naz
Kruger, Danny	
Paul, Rebecca	Woodcock, Sean

Question accordingly agreed to.

Clause 25, as amended, ordered to stand part of the Bill.

Clause 26

Dishonesty, coercion or pressure

Kim Leadbeater: I beg to move amendment 506, in clause 26, page 16, line 7, leave out "in accordance with" and insert "under".

This amendment provides that the offence under subsection (2) applies in relation to an approved substance provided under the Bill.

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

Amendment 507, in clause 26, page 16, line 9, leave out "or (2)".

This amendment limits subsection (3) to offences under subsection (1).

Amendment 508, in clause 26, page 16, line 10, at end insert—

"(4) A person who commits an offence under subsection (2) is liable, on conviction on indictment, to imprisonment for life."

This amendment provides for a maximum penalty of life imprisonment for an offence under subsection (2).

Amendment 509, in clause 26, page 16, line 10, at end insert—

"(5) Proceedings for an offence under this section may be instituted only by or with the consent of the Director of Public Prosecutions."

This amendment provides that proceedings for an offence under this clause may be brought only by or with the consent of the Director of Public Prosecutions.

Clause stand part.

Kim Leadbeater: These amendments to clause 26—and clause 27 to some degree, which I will come on to shortly—are intended to clarify offences under the law. The changes refine the language to ensure that offences relating to dishonesty, coercion and pressure are more clearly defined. The amendments serve to clarify the details of four categories of offences, and I will provide a summary of the four categories.

The first category is when someone

"by dishonesty, coercion or pressure, induces another person to self-administer an approved substance".

This offence, in clause 26(2), is the most serious offence. It is coercing or pressuring someone to take their own life; it includes coercive control and pressure, and it attracts as the maximum a life sentence—the most severe punishment that the law can impose.

The second category of offences includes

"by dishonesty, coercion or pressure,"

inducing

"another person to make a first or second declaration, or not to cancel such a declaration."

This is in clause 26(1). It is where the criminal conduct has coerced or pressured someone to execute or not cancel the declarations—a step in the process, but not actually ending their own life. It is the second most serious offence, and attracts a maximum of 14 years in prison.

The third category of offences involves making or using a false instrument—first declaration, second declaration, medical report or within-six-months-or-less diagnosis—or failing to notify the cancellation of a relevant declaration, with the intention of facilitating the provision of assistance under the Act. That actually comes under new clause 24, which will be discussed in relation to clause 27, but I think it is important to look at the offences in the round. This is the third type of offence. It is a new offence, and it covers cases where a person helps another person to obtain assistance under the Act by falsifying documents to get that assistance or to prevent it from being removed. This is still very serious, and attracts a maximum sentence of 14 years. It will most often be applied where the person seeking the assistance wishes to get round the safeguards. The safeguards must be rigorously enforced, hence the same maximum as for the second category of offence.

4.45 pm

The fourth category of offence involves making or knowingly using a false instrument which purports to be a first declaration, second declaration, certificate of eligibility, or relevant medical certificate, or wilfully ignores a cancellation of a first or second declaration, or fails to comply with the cancellation. This fourth category of offence is designed to deal with any failure, with knowledge, to comply with the requirements of the Bill in relation to documentation. This carries a maximum of five years in prison. This is different from category 3, because it does not depend on proving that the intention is to facilitate the provision of assistance. This is designed to deal with any case where the doctor or other person knows there is something wrong with the relevant document yet continues to use it, or inserts material into the document that is false. It does not matter why they have done it.

The original draft had a potential life sentence for someone who uses the false instrument with the intention of causing death. Having spoken to criminal law experts, we recognise the need for differing degrees of seriousness. I consider that the life sentence should be available, but for the most serious offence, which is coercing or pressuring someone to take their own life. That is reflected in clause 26(2).

Of the four sentencing categories in the Bill, categories 2 and 3 carry the same maximum sentence as the current "assisting or encouraging" offence under the Suicide Act 1961. Therefore, 2 and 3 correctly mirror the activity under the existing law. However, category 1 exceeds anything in the current law. This is because the Bill, for the first time, captures coercion and control in the way that so many who are cautious about the Bill want; and I agree with that. In other words, the protection for the vulnerable enshrined in the new Bill goes further than existing law. That is why the Bill is the answer for those who worry about terminally ill people who may succumb to family pressure to end their life. Category 4 is also new, meaning the types of offending and the sentencing powers that follow mean the Bill is comprehensive and caters for levels of seriousness where the current law is silent.

Amendment 509 ensures that prosecution for any offence under this clause can only be initiated by, or with the consent of, the Director of Public Prosecutions. This is an important safeguard, ensuring that prosecutions are handled with the utmost care and consideration. By involving the Director of Public Prosecutions, we make sure that decisions to prosecute are made fairly, consistently and with proper oversight. This also aligns the approach to assisted dying with the principles of prosecutorial discretion seen in the Suicide Act. This will ensure that cases are reviewed for their individual circumstances before a decision to prosecute is made, ensuring that the individual circumstances of the case are assessed based on the case's merits. The amendments refine and clarify the Bill's provisions by ensuring that legal terminology is more precise, penalties are more aligned with the seriousness of offences, and stronger oversight mechanisms such as the DPP's consent for prosecutions are in place. They aim to protect the integrity of the assisted dying system while offering greater accountability, punishment and deterrence against fraudulent or coercive practices.

Rebecca Paul: I will be fairly brief. I welcome amendment 508, which would ensure that conviction for the offence leads to a necessarily serious result. However, it is not just the strength of the sentence that we need to think about; there is also a question about how difficult it can be to detect and demonstrate coercion in the first place.

Domestic abuse prosecutions have followed an overall downward trend over the past decade, according to Women's Aid. A report from the Domestic Abuse Commissioner in January found the criminal justice system unfit to hold abusers to account and safeguard domestic abuse victims. Domestic abuse victims are being failed by the criminal justice system at every stage, from police to probation. Victims seeking safety in justice routinely face a lack of specialist service referrals, poor enforcement of protective orders, court delays and early release of abusers. The commissioner also found that just 5% of police-recorded domestic abuse offences

reached conviction and that less than a fifth of victims have the confidence to report to the police in the first place. Within the police workforce itself, only 4% of alleged domestic abuse perpetrators are dismissed.

Women's Aid says that trust in the criminal justice system is at an all-time low, with domestic abuse survivors not feeling that they will be believed and supported when reporting abuse. That is even more challenging for black and minoritised survivors, who face additional barriers and poor responses when they seek help.

Kim Leadbeater: The hon. Lady is making a point that we have already covered several times in the debate. It is an important point, but I hope that she is reassured by the offences to be included in the Bill, which create sentences that do not currently exist.

Rebecca Paul: I am absolutely reassured by the hon. Lady's amendment, and I welcome it, but it is worth drawing attention to the fact that the sentence is important but identifying coercion and pressure can be difficult too.

In written evidence, a social worker called Rose has cast doubt on the workability of the Bill. She was writing when the High Court safeguard was still part of the Bill, so we need to bear that in mind, but what she said applies to the panel too. She wrote that

"based on lived experience…there is no authentic provision mechanism or route that cheaply and swiftly would allow an approved palliative care professional…or social worker to act to protect a vulnerable person under the grounds of coercion….Place yourself in a position of being sick or older, coerced by family for financial gain or by a practitioner wanting to save public costs to pursue assisted suicide, the social worker senses it by body language, a squeezing of their wrist, a sharp silencing look. Can you see a judge saying: 'the social worker sensed a tension in the air and a look'.

Do you think that would serve to reach the threshold to override a request for assisted suicide in a court of law?

In practice, what would happen would be, the social worker will record her concerns on the system, share them with her manager who will go to her manager who will say we do not have funds to consult legal and your evidence provided does not reach threshold anyway."

The Chair: Order. I am genuinely trying to give as much latitude as possible, but the issue of coercion has come up before. In the context of the offence, I am not sure that this is necessarily pertinent or relevant. Will the hon. Lady bear that in mind during her speech, please?

Rebecca Paul: Thank you, Mr Dowd. In that case, I will stop there. I was just making the point that this is important.

Amendment 509 states:

"Proceedings for an offence under this section may be instituted only by or with the consent of the Director of Public Prosecutions."

I would find it useful to have more clarity around how the offence is used currently, why it is used and why it is appropriate to use it in this instance. Those are all genuine questions. I simply do not know, so I would be grateful for some input. I will leave it there.

Danny Kruger: I will be grateful if the Minister or the hon. Member for Spen Valley can explain the situations in which behaviour criminalised by clause 26(2) would not also amount to an offence under section 2 of the Suicide Act, as amended, or indeed to murder. What behaviour would be criminalised here that is not already criminal? Can the hon. Lady think of any instance in which there would be no crime under section 2 of the Suicide Act, but there would be an offence under clause 26(2)? If there is no such instance—I cannot think of one—it strikes me that, at least in respect of coercion and pressure, the offence being created here is redundant and duplicative.

Ministers have rightly stressed the importance of their duty to the statute book. My understanding is that having redundant or duplicative legislation, or indeed duplicative offences, would be inconsistent with our duty to the statute book. One might ask, "What does it matter? Wouldn't it be helpful to have additional belt-and-braces safeguards in the Bill?" I agree in principle, but I note that when other Members have deployed that argument in relation to adding terms such as "undue influence", the neutral Ministers have rebuked them by appealing to the duty that we are supposed to have to the statute book. I think the point cuts both ways. Why are we embroidering the statute book with duplicative offences?

Kim Leadbeater: I would have thought, given the hon. Gentleman's views on the Bill, that he would welcome having an actual offence for the purposes of the Bill. Surely that is something that we should all support.

Danny Kruger: I support the principle of insisting that inducing people by dishonesty, coercion or pressure to kill themselves should be illegal, but my understanding is that it already is. If it is not illegal, or if there are circumstances in which we need this additional offence that are not already captured by the Suicide Act or the law on murder, I would like to understand what they are. As I say, while it might be helpful to duplicate the offence, I understand that the very sensible convention in our law is that it is not helpful to have two offences relating to the same act because of the opportunity for offenders to play off one offence against the other.

Having duplicative criminal offences can make prosecuting cases harder because the defendant can raise abuse-of-process arguments about whether they have been charged with the most appropriate offence. I understand that the Attorney General's Office and the Ministry of Justice are therefore usually very keen to avoid duplicative offences.

Let me give an example of the difference in the treatment of the offence. It is proposed that this offence would be subject to a life sentence, which requires the consent of the DPP. But at least in the one case where it overlaps with murder, this would provide a more favourable treatment for the accused than the other obvious charge. Can that be justified?

Duplicating criminal liability by introducing new offences has far-reaching implications that can disturb the coherence and certainty of criminal law. If one introduces a law that gives prosecutors two criminal offences to choose from to cover one act, some prosecutors will choose one and some will choose the other. This is generally undesirable; indeed, it is unprecedented in the case of homicide, where there is every reason to suspect that it could cause chaos for grieving families in search of justice. Such chaos is all too predictable, for a number of reasons.

[Danny Kruger]

Let me give an example. A defendant proven to have procured a suicide by deception will be well advised to plead guilty to the offence contrary to section 26(2) and then contest any attempt to introduce murder proceedings. This matters profoundly. A decision to prosecute is an administrative decision and is subject to judicial review. This is not an academic point; it could cause real distress for bereaved families in deep turmoil seeking justice.

Let us imagine that a person, A, is a new coercive and controlling partner of person B and procures by deception their suicide in order to profit from a will. The family of person B grow suspicious and provide the police with a convincing case for a murder prosecution. The CPS agrees and charges A with murder. A accepts that he procured the suicide by deception. On that basis, he appeals, seeking a remedy in judicial review, saying that the CPS should have charged him with a clause 26(2) offence, not murder. The JR is backed by wealthy pressure groups and is beset with administrative adjournments and so on. From the filing of the claim form to the final judgment of the administrative court within the High Court, the case takes 24 gruelling, painful, awful months for the bereaved family.

Throughout this time, the lawyers for A, the defendant, tell him to stay the course and continue to offer the plea to section 26(2), because the family will be exhausted by the reality of litigation. The family have no legal aid, no support, no charity backing and no one interested in their case. The war of attrition in litigation finally defeats them. They advise the CPS that they will accept a plea under the section 26(2) offence, and not the murder that actually occurred. That is the reality of duplicating criminal liability. In that example, A has got away with murder by judicial review.

We must be clear about what we are being asked to do. It is not simple. We are being asked to innovate in the law of murder. We are being asked to do so without the assistance of the Law Commission, without the careful eye of legal or judicial bodies alive to the difficulties of duplicating liability and without the input of any bodies that represent the victims of crime on how this might affect them. There are no Government consultations with such bodies before us. There is no expert assistance from judicial or legal figures on how the good intentions around clause 26(2) might unintentionally lead to serious and undesirable consequences such as those that I have described.

5 pm

We cannot legislate in the dark on a matter so serious. If the law of murder is to be altered so fundamentally, these questions cannot remain open. They cannot be passed over to the CPS and the judiciary. They cannot be left like a ticking time bomb for someone else to address. Whether Committee members support or oppose this legislation overall does not matter for these purposes; there is a direct challenge here to the integrity of the statute book.

We cannot risk an innovation in the law of murder with the unintended consequence that some murders go unprosecuted and unpunished. We must pass quality law that solves rather than creates problems. I do not intend to oppose the amendments, except amendment 509, as I do not see why the consent of the DPP should be required in the case of dishonesty, coercion or pressure. It is good that there is clarity on what people are prohibited from doing, but I am anxious that the Government discharge their duty to the statute book and that they do so in an even-handed manner.

Naz Shah (Bradford West) (Lab): I thank the hon. Member for East Wiltshire, who has raised some concerns for me. I rise to speak in support of the amendments, but also to raise some points. I share the hon. Gentleman's concerns, but let me begin by speaking about the bits that I feel pleased with and able to support.

My hon. Friend the Member for Spen Valley has already explained the amendments and may explain them more later. I am pleased that they tidy up errors in the original construction of the Bill. In its original form, subsection (2) rightly states:

"A person who, by dishonesty, coercion or pressure, induces another person to self-administer an approved substance provided in accordance with this Act commits an offence."

Unfortunately, in the Bill as drafted, the penalty for such an act is only a prison sentence of 14 years. It is quite right for that to be the penalty for the offence detailed in subsection (1), namely when someone,

"by dishonesty, coercion or pressure, induces another person to make a first or second declaration",

but does not actually succeed in getting them to the end of the assisted dying process. However, it is easy to agree that 14 years is an inadequate penalty for successfully coercing or pressurising somebody into an assisted death. I am glad that my hon. Friend the Member for Spen Valley has recognised that problem and has tabled an amendment that would impose a maximum penalty of life imprisonment for such an offence.

My hon. Friend the Member for Sunderland Central made a powerful speech in this Committee the other day, in which he said that abusive or coercive people are already likely to be forcing their victims to starve themselves or refuse treatment. That is true, and I thank him for raising that important point. I will welcome all measures to make it harder for abusers to do so and will gladly work with hon. Members to do so. However, I want to sound a strong note of caution.

Creating an offence and giving it a strong maximum penalty is only one of the ways to deter abuse and coercion, and perhaps the easiest. As I have mentioned before, the conviction rate for coercion is only about 4%. There are other things that we need to do to deter and prevent abuse. We need the people who may come into contact with it to be aware of what could happen; we need them to be able to spot the signs that it may be happening; we need ways to investigate those signs carefully. Only when we have done those things can we move on to the CPS potentially prosecuting somebody for an offence and, if they are found guilty by the court, to sentencing that person. Those are matters that this clause deals with, and they come at the end of a process.

I welcome the amendment tabled by my hon. Friend the Member for Lowestoft (Jess Asato), which makes training in domestic abuse and coercion mandatory for professionals working on assisted dying cases, and which my hon. Friend the Member for Spen Valley has accepted. However, new training on its own will not be enough to make it near-impossible for abusers to succeed. Having

unfortunately had lots of experience in the area—having seen it in my own life, the lives of people close to me and the lives of constituents—I know that sometimes abusers are not subtle. Even so, they can be hard to catch, because their victims cannot recognise that they are being abused. The classic—I wish I had a pound for every time I heard it—is "He's changed." There are hundreds of justifications and some are very subtle indeed. These people can be very hard to catch, or they may never be caught at all.

I have heard hon. Members say—I think my hon. Friend the Member for Spen Valley said it earlier—that the Bill strengthens the safeguards around people who are terminally ill, because those are not there in the first place. I appreciate that idea, but that is just for those people who are terminally ill. I want to strengthen safeguards more generally. In some ways, the Bill offers people a new opportunity to be coercive, controlling and dishonest. That is why I have been banging on about safeguards so much in this Committee; perhaps people find it a bit much, but I do it because abusers are very persistent and clever people and we have to be clever and persistent in how we devise our safeguards against them.

Although I welcome the clause and the amendments tabled by my hon. Friend the Member for Spen Valley, I am disappointed that other safeguards have been rejected. I still say that the panel procedure could and should be much tougher. That would not guarantee that abusers would be caught, but it would make it more likely.

The Chair: Order. Members cannot continue to talk about the substance of amendments that have already been rejected, and we are now going into that territory. I am not going to stop the hon. Lady talking, but rehashing debates about amendments that we have already had is not in order.

Naz Shah: I apologise, Mr Dowd. I will not refer to them.

I come back to the point made by the hon. Member for East Wiltshire about DPP consent. I will be grateful if the Minister picks up some of these queries. In this place, we make laws. My experience of the law on forced marriage—I was a victim of forced marriage—was that we made a law but never got any convictions. Very little moved on it, because we already had laws in place to prosecute that offence. I am not saying that the same is happening here, but I draw the Committee's attention to the fact that we may be making a law that already exists. If it already exists in the Suicide Act, are we just making a law for the sake of putting something on the statute book or on the face of the Bill?

We have talked a lot about how we should not complicate things. The word "complication" has been used quite a lot in this Committee. Are we adding another layer of complication by putting this measure in the Bill, when we are not prepared to do so for other things that people feel strongly about? This is also something that already exists.

My understanding is that if we were prosecuting coercion, for which unfortunately the prosecution rate is only 4%, that would not need DPP consent. It would be needed, potentially, for assisting suicide, but not for coercion. Do we need some clarity about the application of the law in this regard? Suppose we had a scenario in which somebody was murdered: it was premeditated, and somebody had thought through how to use this process as an avenue to kill that person. I do not want us to make a law that would allow somebody to literally get away with murder. More thought needs to be given to that. I am not an expert or an eminent lawyer like the Minister, but I am concerned by the comments of the hon. Member for East Wiltshire, having looked more closely at the issue. I would welcome the Minister's comments.

Jake Richards: You intimated, Mr Dowd, that we can speak for as long as we want, but I will not speak for long on this clause, partly because I fear that we are making a mountain out of a molehill. The clause creates new criminal offences; I am not a criminal lawyer, but that is my reading of the clause and the amendments tabled to it by my hon. Friend the Member for Spen Valley. There are an array of reasons why criminal offences are legislated for. One good reason is to provide deterrence against committing such an offence. If the Bill receives Royal Assent, we are entering new ground. We are developing a new process in our healthcare system that will affect how our society and culture works, and creating a new legal process, which we had lengthy discussions about when discussing the provisions that will replace clause 12, in the debate over the panel.

In my mind, it is wholly appropriate to have an offence specifically in this very new area. I cannot see any weight to the argument that it undermines the law of homicide in our country and jurisdiction. Respectfully, I cannot see how Members who have been, understandably, worried about the Bill cannot see that this only strengthens it. I would gently say that the arguments that this somehow undermines the law of murder or homicide are slightly disingenuous. I had hoped that debate on this clause would be straightforward, with the Committee seeing that it clearly strengthens the safeguards around assisted dying.

Naz Shah: I have taken your advice, Mr Dowd, because my points would have made for a long intervention. First, I gently remind my hon. Friend the Member for Rother Valley that we have not used the word "disingenuous" in this Committee, so I sincerely wish that he reflects on that. Regardless of the debate we are having, everyone on the Committee is very committed to what we are doing here.

Secondly, my hon. Friend said that we were making a mountain out of a molehill. I refer again to the issue of forced marriage, legislation on which went through the House when police forces already had legislation to prosecute for it. As legislators, we should have ensured that we raised awareness and trained our police officers and communities to apply that—

The Chair: Order. We are dealing with clause 26 and the amendments to it, specifically in relation to these offences. Can the hon. Lady please speak to the clause and the amendments?

Naz Shah: I am speaking to the clause, Mr Dowd. I apologise—I will try to be clearer. Clause 25 creates a new offence, and I am trying to give an example of past

[Naz Shah]

legislation that speaks to the same principle. If we are creating a new offence that the DPP needs to consent to, and we already have an offence, then are we complicating it for the CPS or our police forces?

Take the issue of coercion, because that is what the clause refers to. We only have a 4% conviction rate for coercion. My hon. Friend the Member for Spen Valley referred to a horrific case of a lady who was investigated, and talked about her husband's death. We need to be clearer about what the new offence would lead to. What would it actually protect? Are we protecting cases such as that referred to by my hon. Friend, or we making it more complicated for our law enforcement to police this? Ultimately, if passed, that is what the amendments and the legislation will mean—real-time legislative changes and potential cases to prosecute. That is my point.

5.15 pm

Sarah Sackman: The clause, as amended by amendments 506 to 509, creates two stand-alone criminal offences that apply when a person uses dishonesty, coercion or pressure to induce a person to do a particular act. Subsection (1) creates an offence of inducing another person to make a first or second declaration, or not to cancel such a declaration, by dishonesty, coercion or pressure. That offence, as we heard, will carry a maximum penalty of 14 years' imprisonment, ensuring consistency with the maximum penalty under the Suicide Act.

Subsection (2), as amended by amendment 506, creates an offence of inducing another person to self-administer and approve substances provided under the Bill, by dishonesty, coercion or pressure. Amendment 506 replaces "in accordance with" with "under" for this offence. That gives effect to the policy intent of my hon. Friend the Member for Spen Valley that the offence should capture those who induce a person to self-administer a substance that, due to some error in the process, has not been provided strictly in accordance with the processes in the Bill. The amendment therefore ensures that the offence in subsection (2) will operate effectively.

Amendment 508 inserts proposed new subsection (4) to establish life imprisonment as the maximum penalty for the offence in subsection (2). That amendment gives effect to the policy intent of my hon. Friend by emphasising that inducing someone to undergo an unwanted assisted death through a legal system established by Parliament is a grave offence warranting the most severe penalty of life imprisonment. Amendment 507 is consequential on amendment 508 and amends subsection (3) to reflect the policy intent of my hon. Friend that the offence in subsection (2) should carry a maximum penalty of life imprisonment, rather than 14 years' imprisonment.

Amendment 509, which a number of Members mentioned, amends the clause to provide that neither of the offences could be prosecuted without the consent of the Director of Public Prosecutions. That amendment achieves the policy intent of my hon. Friend that the legislation, first, be consistent with the Suicide Act 1961, which makes the same provision for the DPP's involvement and where such consent is required; and, secondly, to ensure that spurious prosecutions are not brought, for example, by those who may oppose the process that the applicant for assisted dying is undergoing simply because they oppose it, rather than because of any illegality or criminality. That is the function of having the DPP consent baked into the legislation.

To be clear, the terms "coercion", "dishonesty" and "pressure" remain undefined in the clause. That was an issue that we touched on right back in the early days of clause 1. Without a statutory definition, the terms will carry their natural, ordinary meaning, well understood by the public and the courts alike.

I want to pick up on two other points touched on in various speeches. The first has to do with the issue of coercion, coercive control and its subtleties, the way in which that is dealt with and, indeed, the painfully low conviction rates for domestic abuse and coercion. I am not seeking to make a wider political point beyond the amendments that we are discussing, but the hon. Member for Reigate and my hon. Friend the Member for Bradford West know that the Government have a mission to halve violence against women and girls. I assure the Committee that, in my capacity as Minister of State in the Ministry of Justice, we are intently focused on addressing that, and ensuring that the criminal justice system plays its part more widely. The offences sit in that context.

The other point that I want to address, and touched on earlier, was the one made by the hon. Member for East Wiltshire about our duties to the statute book. It is right that there is a degree of duplication and to acknowledge that, as the Government do in working with the promoter of the Bill to reflect her policy intent. That is not unusual. It is something those in law enforcement, in particular in the CPS, are well versed in. It will be for them to make the appropriate charging decisions, depending on the facts in the particular case.

The function of the offence created under subsection (2) and the penalty attached to it affect the gravity that the promoter of the Bill sought to indicate for the offence of inducing someone to undergo something through dishonesty, coercion or pressure, in the context of what we all acknowledge is a new process. If the Bill is passed, there will be a new legal regime for assisted dying. The manipulation of such a new regime to ends that are criminalised under the provision is reflected in that specific offence. To be clear, the degree of duplication is acknowledged, but the Government's view is that that is neither unusual nor poses a problem for the CPS.

Danny Kruger: That is helpful and makes sense. The only justification for duplication must be that the duplication is only partial, which the Minister has just suggested it is. Not a complete overlap—some cases will fall into one category, but not into the other. I wonder if she could help us to understand with an example that would help the CPS when it makes its decisions about which offence to charge someone under—an example of an offence that would be illegal under this clause and not already illegal under the Suicide Act or the laws of homicide.

Sarah Sackman: I am not going to answer that question directly, because I will not get into hypotheticals, which would be a test. I understand the question the hon. Gentleman is asking. As I said, the policy intent here—the policy of including the specific offence within the context of this new legal regime and the signal that doing so

would send to all those participating in this regime by attaching the severest penalty of life imprisonment to the offence created under subsection (2)—has been a matter for the Bill's promoter. The Government have worked with her to create a workable regime.

I will not proffer on my feet a hypothetical factual scenario that would be caught by this offence, but would not be caught under other offences that exist in our criminal law. The point is that overlapping criminal offences exist in our criminal law. That is not unusual. The CPS is well versed in dealing with that. The charging decisions will be for the CPS, with the consent of the DPP. Satisfying the purpose of having criminal liability—to catch those who perpetrate what would be, in any view, a heinous crime, and to deter such crime—would be discharged by the drafting that we have here.

Danny Kruger: I respect the difficulty of the position that the Minister is in, but I am afraid that we have to consider hypothetical scenarios, because we are creating law. Does she acknowledge that, even if she cannot imagine, or cannot suggest to us, a case that falls under the provisions of this clause, but is not caught by the Suicide Act or law of murder, someone who is charged with murder could plausibly claim that, in fact, they should have been charged with the offence under clause 26(2) of the Bill? Plausibly, they could make a case, perhaps through judicial review, that the charging decision was wrong, and we would have months of litigation before we even got to the prosecution beginning. Can she envisage such a scenario happening?

Sarah Sackman: I find that highly implausible; the likelihood is that the CPS will apply the appropriate charging decision to fit the facts as they have arisen. If they have arisen within the context of this legal regime, for someone acting nefariously, dishonestly or coercively about assisted dying, the charge under this clause would be the appropriate one. I find it implausible that the other scenario would arise. As I said, the CPS is well versed in applying the appropriate charging decision to the appropriate crime on the facts of the crime. I will not speculate or hypothesise on what that might be.

Kit Malthouse: As the Minister said, this is not an unusual exercise for the CPS and operates in lots of other areas. For example, the CPS regularly makes decisions about whether to charge someone with grievous bodily harm under section 18 or section 20 of the relevant legislation—they are both forms of GBH. Which one the CPS chooses depends on the circumstances, the seriousness and the level of intent. As she said, the charge naturally—whether it falls under the same Act or a different Act—comes down to the circumstances.

Sarah Sackman: That is a good example. One knows from charging decisions that often, on indictment, one might have multiple offences to capture the totality of the criminal behaviour. Some of those may be made out, some of them may not. What the Government have sought to do here, working with the Bill's promoter, is to reflect her policy intent: to convey the gravity of the offence in this wholly new legal regime. As the right hon. Gentleman pointed out earlier, we are sanctioning and decriminalising conduct that has previously been criminal, while ensuring that this offence captures what would be criminal under the new legal regime. From the promoter's point of view, it is important to signal that the Government have worked with her on this, and the Government's position is that the result, in this amended form of the Bill, gives both some satisfaction to her policy intent and is compatible with how our criminal law routinely works, so it is workable from the point of view of the CPS.

Danny Kruger: I acknowledge the point that the Minister is making. To the point made by my right hon. Friend the Member for North West Hampshire, we are talking not about two categories of offence within the same legal framework, namely GBH, but about two different legal frameworks altogether, the law of homicide and the law on assisted dying. Does the Minister agree that the clause as it is to be amended will create the opportunity for a murderer who would otherwise be convicted of or charged with murder to claim that, in fact, he was committing an offence under the assisted suicide law? We are creating a new opportunity for someone who would otherwise, were it not for this law, be legitimately charged with murder to claim that they are committing this offence instead.

Sarah Sackman: I do not consider that through this amended form of the Bill—if the Committee chooses to vote that way—we will have created an opportunity that could be exploited in that way. The hon. Gentleman said earlier that there has not been consultation on that point, but there has been close working of highly experienced Government lawyers with the promoter to reflect her policy intent.

What the clause interlocking—and indeed overlapping, as I have acknowledged—with the Suicide Act does is prescribe new forms of criminal offence and liability that will capture criminal behaviour, which is ultimately what the measure is about. Tellingly, the punishment attached to the clause 26 offence is the same as the maximum punishment for murder, that of life imprisonment, which is indicative of the gravity of the offence that would be caught.

Kim Leadbeater: That is the point I would like to make: the penalty is the same, but it is important that the offence is specific, hence why I have put it in the Bill. The outcome for the criminal involved, however, would be the same.

Sarah Sackman: That is all I intend to say on this matter. I think we have probably ventilated this particular issue as far as we can.

Amendment 506 agreed to.

Amendments made: 507, in clause 26, page 16, line 9, leave out "or (2)".

This amendment limits subsection (3) to offences under subsection (1).

Amendment 508, in clause 26, page 16, line 10, at end insert—

"(4) A person who commits an offence under subsection (2) is liable, on conviction on indictment, to imprisonment for life."—*(Kim Leadbeater.)*

This amendment provides for a maximum penalty of life imprisonment for an offence under subsection (2).

5.30 pm

Amendment proposed: 509, in clause 26, page 16, line 10, at end insert—

"(5) Proceedings for an offence under this section may be instituted only by or with the consent of the Director of Public Prosecutions."—*(Kim Leadbeater.)*

This amendment provides that proceedings for an offence under this clause may be brought only by or with the consent of the Director of Public Prosecutions.

Question put, That the amendment be made.

The Committee divided: Ayes 19, Noes 1.

Division No. 67]

AYES

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

NOES

Kruger, Danny

Question accordingly agreed to.

Amendment 509 agreed to.

Clause 26, as amended, ordered to stand part of the Bill.

Clause 27

FALSIFICATION OR DESTRUCTION OF DOCUMENTATION

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

"(iii) a certificate of eligibility,".—*(Kim Leadbeater.)*

This amendment is consequential on NC21.

[CAROLYN HARRIS *in the Chair*]

Kim Leadbeater: I beg to move amendment 510, in clause 27, page 16, line 18, leave out "wilfully" and insert "intentionally or recklessly".

This is a drafting change, aligning the wording used here with wording used elsewhere in the clause.

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

Amendment 511, in clause 27, page 16, line 22, leave out "that person" and insert "a relevant matter".

This amendment and amendment 512 clarify that the offence under subsection (2) relates only to an opinion about a matter relating to a function under the Bill.

Amendment 512, in clause 27, page 16, line 23, at end insert—

"(2A) In subsection (2) "relevant matter" means a matter relating to any function under this Act."

See the statement for amendment 511.

Amendment 513, in clause 27, page 16, line 24, leave out subsection (3) and insert—

"(3) A person commits an offence if they intentionally or recklessly fail to comply with an obligation under—

(a) section 14(1A) or (2) (notification of cancellation of declaration), or

(b) section 17 (recording of cancellations)."

This amendment clarifies the scope of the offence under subsection (3), by providing that the offence occurs where a doctor fails to comply with a notification or recording obligation in relation to the cancelling of a first or second declaration.

Kim Leadbeater: These amendments relate to the falsification or destruction of documentation and are very straightforward. Amendment 510 makes a drafting change to align the wording of subsection (1)(b) with wording used elsewhere in the clause. Amendments 511 and 512 clarify that the offence under subsection (2) relates only to an opinion about a matter relating to a function under the Bill rather than to the person. Amendment 513 clarifies the scope of the offence under subsection (3) by providing that the offence occurs where a doctor fails to comply with a notification or recording obligation in relation to the cancelling of a first or second declaration.

The amendments significantly improve the clarity, scope and precision of the offences in clause 27, align it with the language used in the rest of the Bill and ensure that it is more consistent. They refine the original provisions, focusing on serious misconduct and offences covered by the clause.

Danny Kruger: It is good to see you this evening, Mrs Harris.

I have no objection to the hon. Lady's amendments. I think there is value in broadening the offence to include actions performed intentionally or recklessly, as that is critical for patient safety. Given the finality of the result of assisted death, there should not be any room for carelessness, and liability must ensure that not only deliberate misconduct but negligent record keeping is subject to legal scrutiny. I want to put on the record the evidence we had from the *British Journal of Nursing*, which has documented the serious risks of poor record keeping in medical practice. That demonstrates how inadequate documentation contributes to clinical errors.

I think the hon. Lady recognises that this is not just a matter of bureaucratic tidying-up. The principle is straightforward: if the decision to assist in ending a life is to be lawful, the documentation supporting it must be unimpeachable. Expanding liability to cover reckless documentation is entirely consistent with existing legal and professional standards in the UK medical profession.

Sarah Sackman: It is a pleasure to serve under your chairmanship, Mrs Harris. I will be brief. As we have heard, clause 27 creates various stand-alone criminal offences regarding the falsification or destruction of documentation related to assisted dying. Amendment 510 replaces "wilfully" with "intentionally or recklessly" in subsection (1)(b), to align the wording with that used elsewhere in the clause. The Government have worked with my hon. Friend the Member for Spen Valley on the other amendments, to tighten up and improve the workability and operability of the Bill.

Amendment 510 agreed to.

Amendments made: 511, in clause 27, page 16, line 22, leave out "that person" and insert "a relevant matter".

This amendment and amendment 512 clarify that the offence under subsection (2) relates only to an opinion about a matter relating to a function under the Bill.

Amendment 512, in clause 27, page 16, line 23, at end insert—

"(2A) In subsection (2) "relevant matter" means a matter relating to any function under this Act."

See the statement for amendment 511.

Amendment 513, in clause 27, page 16, line 24, leave out subsection (3) and insert—

"(3) A person commits an offence if they intentionally or recklessly fail to comply with an obligation under—

(a) section 14(1A) or (2) (notification of cancellation of declaration), or

(b) section 17 (recording of cancellations)."—*(Kim Leadbeater.)*

This amendment clarifies the scope of the offence under subsection (3), by providing that the offence occurs where a doctor fails to comply with a notification or recording obligation in relation to the cancelling of a first or second declaration.

Kim Leadbeater: I beg to move amendment 514, in clause 27, page 16, line 28, leave out subsection (4).

This amendment is consequential on NC24.

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

Amendment 515, in clause 27, page 16, line 31, leave out from beginning to "an" and insert "A person who commits".

This amendment is consequential on amendment 514.

Amendment 516, in clause 27, page 16, line 36, at end insert—

"(6) Proceedings for an offence under this section may be instituted only by or with the consent of the Director of Public Prosecutions."

This amendment provides that proceedings for an offence under this clause may be brought only by or with the consent of the Director of Public Prosecutions.

New clause 24—*Falsification of documentation etc with intention that another will obtain assistance to end own life*—

"(1) A person commits an offence if, with the intention of facilitating the provision of assistance to a person (B) under this Act to end their own life, they—

(a) make or knowingly use a false instrument which purports to be—

(i) a first declaration,

(ii) a second declaration, or

(iii) a certificate of eligibility,

(b) provide a medical or other professional opinion in respect of B which is false or misleading in a material particular, or

(c) fail to comply with an obligation under section 14(1A) or (2) (notification of cancellation of declaration).

(2) In subsection (1) the reference to assistance under this Act includes assistance purporting to be under this Act.

(3) A person who commits an offence under this section is liable, on conviction on indictment, to imprisonment for a term not exceeding 14 years.

(4) Proceedings for an offence under this section may be instituted only by or with the consent of the Director of Public Prosecutions."

This new clause creates an offence in respect of certain conduct, where the person engaging in the conduct does so with the intention of enabling another person to obtain assistance under this Act (or assistance purportedly under this Act).

Kim Leadbeater: In combination, amendments 514 to 516 and new clause 24 refine and strengthen the legal framework surrounding assisted dying, shifting the focus towards serious fraudulent misconduct and the falsification of documents, and ensuring that prosecutions are conducted with careful oversight by the Director of Public Prosecutions. These changes mark a clear departure from the original drafting, which focused clause 27 more generally on non-compliance with administrative duties, and introduce more severe consequences for deliberate wrongdoing related to the assisted dying process.

New clause 24 is an important addition to the Bill. It creates an offence in respect of certain conduct, where the person engaging in the conduct does so with the intention of enabling another person to obtain assistance under the Act. I made some comments about that previously, so I will leave it there for now, but I hope the Committee will join me in supporting the amendments and new clause.

Sarah Sackman: I intend to be brief. New clause 24 and amendments 514 to 516 create stand-alone criminal offences relating to the falsification or destruction of documentation where a person acts with the intention of facilitating the provision of assistance to another person to end their own life under the Bill. That reflects the policy intent of my hon. Friend the Member for Spen Valley that those who falsify documents with the specific intent of facilitating another to end their life should be subject to a higher maximum penalty than those offences in clause 27.

Amendment 514 agreed to.

Amendments made: 515, in clause 27, page 16, line 31, leave out from beginning to "an" and insert "A person who commits".

This amendment is consequential on amendment 514.

Amendment 516, in clause 27, page 16, line 36, at end insert—

"(6) Proceedings for an offence under this section may be instituted only by or with the consent of the Director of Public Prosecutions."—*(Kim Leadbeater.)*

This amendment provides that proceedings for an offence under this clause may be brought only by or with the consent of the Director of Public Prosecutions.

Clause 27, as amended, ordered to stand part of the Bill.

Clause 28

Prescribing, dispensing, transporting etc of approved substances

Sean Woodcock (Banbury) (Lab): I beg to move amendment 442, in clause 28, page 17, line 3, leave out "may" and insert "must".

This amendment will make it an obligation for the Secretary of State to make regulations on the prescribing and dispensing of approved substances, their transportation, storage, handling and disposal and the associated records with this.

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

Amendment 443, in clause 28, page 17, line 4, after "substances" insert

"as approved through the Medicines and Healthcare products Regulatory Agency and either the National Institute for Clinical Excellence or the All Wales Medicines Strategy Group processes".

This amendment requires any regulations made about the prescribing and dispensing of approved substances to be on substances approved through the Medicines and Healthcare products Regulatory Agency and either the National Institute for Clinical Excellence or the All Wales Medicines Strategy Group processes.

Amendment 444, in clause 28, page 17, line 6, after "substances" insert

"including specifying that approved substances must at no time be left unsupervised by a medical practitioner".

This amendment will ensure regulations about the storage and handling of approved substances specify that approved substances must at no time be left unsupervised.

Amendment 445, in clause 28, page 17, line 9, leave out "may" and insert "must".

This amendment ensures that the regulations under subsection (1) include provision about enforcement including provision of imposing civil penalties.

Amendment 521, in clause 28, page 17, line 11, leave out subsection (3) and insert—

"(3) The Secretary of State may not make a statutory instrument containing (whether alone or with other provision) regulations under subsection (1) unless a draft of the instrument has been laid before, and approved by a resolution of, each House of Parliament."

Amendment 485, in clause 28, page 17, line 11, leave out "negative" and insert "affirmative".

Clause stand part.

Sean Woodcock: It is a pleasure to have you in the Chair for the rest of our proceedings today, Mrs Harris. I rise to speak to amendment 443, tabled by my hon. Friend the Member for York Central (Rachael Maskell), which would ensure that the drugs used for assisted death are approved by established regulatory bodies.

We know from evidence from other countries with assisted dying laws that the lethal drugs used can result in uncomfortable complications, even if in only a minority of cases. None of us would wish for that to be the case should this legislation be introduced. Unfortunately, the data on assisted dying recipients who suffer complications is nowhere near as thorough as we would like it to be, but it stills show us some important facts about what some people go through during the assisted dying process.

For example, the latest annual report on assisted dying from the state government of Western Australia states:

"No data on length of time to death, administration location or complications is collected by the Voluntary Assisted Dying Board regarding deaths occurring via self-administration of the voluntary assisted dying substance."

The Western Australia authorities do gather data on the rate of complications among assisted dying recipients who receive practitioner assisted death, where a doctor administers the drug. They found that in 4.3% of those assisted deaths in 2023, the patient suffered complications, which included

"worsening of pain or discomfort…and regurgitation/vomiting…Complications reported as other included coughing and/or burning of the throat following assisted oral ingestion, hiccups with gastric reflux, involuntary muscular contractions, and delayed loss of consciousness. All patients with reported complications died after administration of the voluntary assisted dying substance."

I understand that the Bill does not propose that a doctor would administer the substance themselves, but I do not think that means that the Western Australia data is irrelevant. Whatever drugs are administered under the Bill will likely be similar to, or the same as, those administered in Western Australia. If the Bill passes, some of the people who undergo assisted dying in England and Wales are likely to suffer the same kinds of complications. For that reason, we cannot allow drugs to be prescribed in order to end people's lives without first undertaking the most rigorous tests. In particular, we need to investigate how likely they are to give the patient a prolonged death or to worsen the patient's pain.

5.45 pm

Expert pharmacologists who submitted evidence to the Committee also stressed the need for thorough investigation of the drugs that would be used for assisted dying. In written evidence submission TIAB 255, 17 clinical pharmacologists noted that a 2018 review of Canada's assisted dying law came to some disturbing conclusions. The review of the Canadian experience found:

"Overall the quality of evidence for their use is low. Most available evidence is unpublished or limited to expert opinion, observational data, and experiential data".

Kim Leadbeater: My hon. Friend is making some interesting points, but I think they are probably more relevant to the debate we had the other day on clause 18. Clause 28 is about the prescribing, dispensing and transporting of approved substances, rather than the substances themselves.

Sean Woodcock: I do not accept that they are not relevant to this clause, I am afraid, but I take on board my hon. Friend's point. If I may finish my quote, the review continued:

"There is some difficulty in determining which coma inducing mixture has the most evidence, based on the lack of comparative data between each drug regime and different dose trials."

In their evidence, the pharmacologists wrote:

"Monitoring of drug efficacy and safety should be compulsory in order to assure good clinical care and comply with regulations."

I agree with that sentiment, and I hope that all hon. Members would too.

The right institutions to approve drugs before use and then monitor their safety during use are those that are named in amendment 443. All substances used for assisted dying must be approved through the Medicines and Healthcare products Regulatory Agency and either the National Institute for Clinical Excellence or the All Wales Medicines Strategy Group processes. There are significant risks if this rigorous process is not undertaken. The drugs used for assisted dying must be tested to ensure that they are safe and effective for use in assisted death.

Kit Malthouse: I am very sorry to intervene on the same point as the hon. Member for Spen Valley, but clause 28 is not about the formulation of the drugs or their approval; it is about the administration of the issuing of the drugs by a pharmacist or otherwise. I am sorry if I am misconstruing the hon. Gentleman, but I think he might be off on a bit of a tangent, on a debate

that, as the hon. Lady said, we had earlier. As I say, this clause is about the bureaucratic process of the issuing the drugs, not about their formulation or approval.

Sean Woodcock: I would suggest—

The Chair: Order. Before the hon. Member continues, may I ask him if he will talk about the transporting of the drug and not the drug itself, and then we will stay in scope?

Sean Woodcock: Okay. I would suggest that part of the bureaucracy—

The Chair: Order. Mr Woodcock, it is not up to you to make those decisions. I would appreciate it—

Sean Woodcock: In response to the point that the right hon. Member for North West Hampshire made—

The Chair: Order. I am speaking, Mr Woodcock. I have given an instruction and it is your job to take it. Could we stick to the amendment?

Sean Woodcock: I understand. I have said what I need to say on the amendment. I believe that it is relevant. I take your advice, Mrs Harris, but I commend it to the Committee.

Sojan Joseph (Ashford) (Lab): I rise to speak in support of these important amendments. The prescribing, dispensing and transporting of these medications is very important. In my experience, and as the Care Quality Commission reports, many healthcare settings have issues with the storage and disposal of medications. Amendment 442 is a straightforward one that would change "may" to "must". I think it is right that the Secretary of State "must" by regulations make the provisions listed.

In oral evidence, we heard of one incident in Australia where the patient was given medication and did not take it but passed away, and then her partner took it and died. Amendment 444, which would provide that the substances must not be left unsupervised by a medical practitioner at any time, is very important. I urge the Committee to accept it, and amendment 445, which would also change a "may" to a "must". These are straightforward but important amendments that seek to safeguard relatives, staff and the public. We must not leave these medications unattended at any time.

Danny Kruger: It is a pleasure to follow the hon. Members for Ashford and for Banbury. I entirely concur with their points, particularly those that derive from the expertise of the hon. Member for Ashford.

This is a very important group of amendments, which concern what is in a sense the heart of the Bill—the management of the lethal drugs. The question of what drugs we are talking about remains open, which is a cause of deep concern to me, but whatever they happen to be, we need to make sure that the management—the regime of dispensing, transporting and prescribing—is safe.

I will not reprise the details of all the amendments. Their purpose is to ensure a stricter, more transparent and safer regime for the management of the drugs. Amendment 521, which is in my name, would ensure that the regulations that we arrive at are laid before Parliament, and debated and approved by both Houses of Parliament. Amendment 485 in the name of the hon. Member for York Central would address the same issue.

The amendments seek to address the dangerous absence of an adequate regulatory regime in the Bill for the lethal drugs and approved substances. Once again, significant questions are ignored in clause 28. Ministers will be given the power to make regulations for the prescription, dispensing, transportation, storage, handling and disposal of approved substances. The clause is envisaged as sufficient for an entire regulatory regime for approved substances. It is just 87 words. It is as if it is an afterthought—as, it seems, is the role of pharmacists, by the way.

The regulations are subject to the negative procedure, which means they are highly unlikely to be debated at all or voted upon, for reasons given in my earlier complaints about the use of the negative procedure. Indeed, it is discretionary whether the regulations will be made at all.

Last night, the Minister told us that the Government objected to the Medicines and Healthcare products Regulatory Agency approving the drugs or substances in amendment 465, which I had tabled. He said:

> "The Government's assessment of amendment 465 is that it would significantly impact the legal and operational delivery of the Bill. The Government anticipate that all substances used for assisted dying will have existing licences from the Medicines and Healthcare products Regulatory Agency for other indications, but the amendment would require the approved substances to be licensed by the MHRA specifically for the purpose of assisted dying."—[*Official Report, Terminally Ill Adults (End of Life) Bill Public Bill Committee,* 18 March 2025; c. 1224.]

That was indeed the purpose of that amendment.

If there is anxiety that I am somehow straying from the relevant clause and amendments, which I detect from Members who are clearly looking forward to their dinner, I do insist—[*Interruption.*]

The Chair: Order. Mr Kruger, can we please stick to the point?

Danny Kruger: Sorry, Mrs Harris. I do not appreciate the sense of impatience in the Committee; these are very important matters.

The Chair: Can we just stick to the point, please?

Danny Kruger: Absolutely; that is what I am doing.

I referenced the debate we had last night, which I hope is within scope, because the suggestion has been either that the Bill insufficiently addresses the need for a regulatory regime for the approval of drugs specifically for the purpose of assisted dying or, as the Government are saying, that the drugs' existing licences are sufficient for these purposes. Is the Government's position that there will be no regulator involved and that this will sit entirely with the Minister, as in this clause? If regulators are to be involved, will further legislation be needed?

[Danny Kruger]

I will not repeat evidence from the Royal Pharmaceutical Society concerning the legal arrangement, but I will refer to evidence submitted by Máire Stapleton, a pharmacist with more than 30 years' experience in clinical governance, who made this point:

"Based upon a preliminary review of current published data, it is difficult to see how the regulatory and professional standards for prescribing and dispensing unlicensed drugs can be met."

There is further evidence to that effect from the Royal Pharmaceutical Society, pharmacists and barristers.

Given that there is so little on the face of the Bill and no guardrails for the use of the power that will be given to the Secretary of State, why is the negative procedure judged appropriate for something of this significance? It cannot be argued that the negative procedure is needed because the amendments might need to be made quickly and frequently—that cannot be the case, because we have not yet authorised the regime. The negative procedure would allow the Secretary of State quite unjustified ability to change these processes without any requirement for a parliamentary debate or vote.

Lord Hermer, the Attorney General, has said that this new Government will take a new approach, considering the

"real need to consider the balance between primary and secondary legislation, which in recent years has weighed too heavily in favour of delegated powers."

He criticised the previous Government's

"excessive reliance on delegated powers, Henry VIII clauses, or skeleton legislation,"

which

"upsets the proper balance between Parliament and the executive. This not only strikes at the rule of law values I have already outlined, but also at the cardinal principles of accessibility and legal certainty.

In my view, the new Government offers an opportunity for a reset in the way that Government thinks about these issues. This means, in particular, a much sharper focus on whether taking delegated powers is justified in a given case, and more careful consideration of appropriate safeguards."

I conclude with this question to the Minister: has she considered the advice of Lord Hermer in coming to a view on the appropriateness of this clause and the way that these powers have been taken? As the Hansard Society notes,

"the Government has an overriding duty of care to the statute book. As such, any powers that may accrue to Ministers because of a Private Member's Bill must be acceptable to the Government. It must therefore take a view on the powers and their scrutiny".

Has the sponsor or the Minister consulted with the Royal Pharmaceutical Society on the sufficiency of this power? Has sufficient work been done to look at the workability and operationalisation of this clause? I hope the Committee will join me in supporting these amendments.

Stephen Kinnock: It is a great pleasure to serve under your chairship today, Mrs Harris. Amendment 442 would require the Secretary of State to make regulations for the prescribing, dispensing, transporting, storage, handling and disposal of approved substances, including the keeping of records relating to those activities. That differs from the Bill's current approach, which enables the exercise of a power by the Secretary of State to make such regulations.

In practice, where the Secretary of State makes regulations specifying substances for the purpose of the Bill under clause 20, they will necessarily also make regulations for the prescribing, dispensing and transporting of said substances under clause 28. However, requiring, rather than enabling, the regulations under clause 28 to be made may reduce flexibility in terms of their timing as there is a range of technical issues that may need to be resolved—for example, clinical questions on how an approved substance should be prescribed or dispensed.

Amendment 443 would mean that regulations for the prescribing and dispensing of approved substances could be made only in relation to substances that have already been approved by

"the Medicines and Healthcare products Regulatory Agency and either the National Institute for Clinical Excellence or the All Wales Medicines Strategy Group".

That may impact the operational delivery of the Bill as the drafting is ambiguous. One possible interpretation is that the amendment may require the approved substances to be licensed by the MHRA specifically for the purpose of assisted dying. That would require additional powers to amend medicines regulations, which are not currently provided for in the Bill. NICE and the All Wales Medicines Strategy Group typically make recommendations only on medicines that have already been proven to be safe and efficacious. They do not approve medicines in the way the amendment implies, and this could infringe upon the role of the MHRA.

6 pm

I turn to amendment 444. As the Bill currently stands, the Secretary of State may by regulations make provisions relating to the prescribing, dispensing, disposal and transporting of approved substances. If the amendment were accepted, regulations made by the Secretary of State relating to the transportation, storage, handling and disposal of approved substances would need to specify that those substances must at no time be left unsupervised by a medical practitioner. The operational impact of the amendment would be to place a duty on a medical practitioner to ensure that approved substances must at no time be left unsupervised. That would increase the obligations on the co-ordinating doctor, and potentially any medical practitioners with access to approved substances. It is unclear when the duty on the medical practitioner would apply. For example, would it apply when the approved substance is in transit, or only once it has been provided to the person?

Naz Shah: Would the Government's intention not be to sign this duty over to a regulator?

Stephen Kinnock: My understanding is that the amendment would place the duty on a medical practitioner. I am speaking to the purpose and effect of the amendment, which is not about a regulator; it is about a medical practitioner. Does that answer my hon. Friend's question?

Naz Shah: I am not sure, but I will give it more thought.

Stephen Kinnock: Amendment 445 would require that the Secretary of State make regulations about enforcement, including provision of imposing civil penalties, when making regulations for prescribing, dispensing, transporting, storage, handling and disposal of approved substances, including the keeping of records relating to those activities. That would be a change from the current approach in the Bill, which gives a power to the Secretary of State to make such provisions. In practice, where the Secretary of State makes regulations specifying substances under clause 20, they will necessarily make regulations under clause 28 for the prescribing, dispensing and transporting of said substances, and on enforcement, which would include imposing civil penalties.

Danny Kruger: Further to the intervention from the hon. Member for Bradford West, I would like to understand whether the Minister envisages an independent regulator of any sort being responsible for overseeing the regime? We currently do not know what that will be—a future Secretary of State will design it—but does he envisage that there will be some sort of regulatory body with that job, and if not the MHRA, who?

Stephen Kinnock: We will at some point get to clause 32, which is about the way in which the system will work, specifically with the NHS, and the role of regulation will absolutely be debated in that context. My sense is that it would be best to confront that issue when we debate clauses 32 and 39. Officials are currently working with the promoter of the Bill, my hon. Friend the Member for Spen Valley. We know that her policy intent is for the service to be an integral part of the NHS, but with some flexibility in the way it is delivered; we have briefly touched on that in previous debates. As an integral part of the NHS, it will have to be a regulated service, based on the foundations of the way in which the NHS is regulated more broadly. I think the answer to the hon. Gentleman's question is basically yes, but the right place to debate it and potentially amend the Bill would be in clauses 32 to 39.

Danny Kruger: We look forward to the amendments that the Government are working on, but, as part of that process, does the Minister envisage that there will be amendments to NHS legislation itself?

The Chair: Order. We need to discuss the amendment, not speculate about the future.

Stephen Kinnock: Thank you, Mrs Harris; you have helped me to answer the hon. Gentleman's question in a far more pithy and direct way than I could have. I think it is best for us to wait for us to discuss clauses 32 and 39, when we can really get into the meat of the precise issue he raised.

Amendment 521 would change the requirements in clause 28 so that regulations governing the prescribing, dispensing, transporting, storage, handling, disposal and records relating to these activities of approved substances under the Bill must be laid in draft form and approved by resolution in each House of Parliament. This is a change from the current requirement in the Bill that the regulations are subject to the negative procedure. Both procedures are subject to Parliamentary scrutiny. However, the requirement for active debate in both Houses of Parliament as a result of the amendment would extend the timeline to make or change regulations.

Amendment 485 is similar. It would alter the requirement in clause 28 that regulations governing prescribing, dispensing, transporting, storage, handling, disposal and records relating to these activities of approved substances are subject to the affirmative procedure, instead of the negative procedure as drafted. Similar to the change of procedure proposed by amendment 521, the affirmative procedure would extend the timeline to make or change regulations.

That is the end of my observations. I hope they were helpful to the Committee.

Kim Leadbeater: I will speak briefly about amendments 485 and 521, on which I will respectfully disagree—not for the first time—with the hon. Member for East Wiltshire. I believe the negative procedure is perfectly adequate in matters of this kind. We had a similar debate the other day.

I will also speak to amendments 442 and 445 in the name of my hon. Friend the Member for York Central. Although I take on board the comments of the Minister about time pressures, I am minded to support both these amendments. Regulations are important and I have no problem with placing the duty on the Secretary of State in those two instances.

Danny Kruger: It might appear a procedural issue, but does the hon. Lady acknowledge that there is a profound difference between the negative and affirmative procedure? Why is she content that the regime for the regulation of these lethal drugs, which are at the absolute core of her Bill, be subject to the discretion of the Secretary of State, without any likelihood or any real possibility of any sort of debate in Parliament? Why should this not be through the affirmative procedure?

Kim Leadbeater: I am not aware of any situation in which we debate the drugs for any other type of medical provision or healthcare. I appreciate the gravity of the situation but, with all due respect to colleagues, we are not best placed to make those kinds of decisions and it is unnecessary for us to have that debate. Clinicians and experts in pharmacology and medicines are best placed to do that, under the guidance of the Secretary of State.

Danny Kruger: Nevertheless, the hon. Lady is proposing that this passes through Parliament, just through the negative procedure. If she thinks there is an appropriate rubberstamp by Parliament—that Parliament needs to approve this regime—why should it not have the opportunity to debate it?

Kim Leadbeater: As I have said, I think the negative procedure is the correct level of parliamentary involvement in that process.

Amendment 442 agreed to.

Amendment proposed: 443, in clause 28, page 17, line 4, after "substances" insert

"as approved through the Medicines and Healthcare products Regulatory Agency and either the National Institute for Clinical Excellence or the All Wales Medicines Strategy Group processes".—*(Sean Woodcock.)*

This amendment requires any regulations made about the prescribing and dispensing of approved substances to be on substances approved through the Medicines and Healthcare products Regulatory Agency and either the National Institute for Clinical Excellence or the All Wales Medicines Strategy Group processes.

Question put, That the amendment be made.

The Committee divided: Ayes 6, Noes 15.

Division No. 68]

AYES

Francis, Daniel	Olney, Sarah
Joseph, Sojan	Shah, Naz
Kruger, Danny	Woodcock, Sean

NOES

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

Question accordingly negatived.

Amendment made: 445, in clause 28, page 17, line 9, leave out "may" and insert "must".*—(Kim Leadbeater.)*

This amendment ensures that the regulations under subsection (1) include provision about enforcement including provision of imposing civil penalties.

Amendment proposed: 521, in clause 28, page 17, line 11, leave out subsection (3) and insert—

"(3) The Secretary of State may not make a statutory instrument containing (whether alone or with other provision) regulations under subsection (1) unless a draft of the instrument has been laid before, and approved by a resolution of, each House of Parliament."*—(Danny Kruger.)*

Question put, That the amendment be made.

The Committee divided: Ayes 3, Noes 19.

Division No. 69]

AYES

Kruger, Danny	Paul, Rebecca
Olney, Sarah	

NOES

Abbott, Jack	Malthouse, rh Kit
Atkinson, Lewis	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	Tidball, Dr Marie
Kinnock, Stephen	Woodcock, Sean
Leadbeater, Kim	

Question accordingly negatived.

Amendment made: 215, in clause 28, page 17, line 11, leave out subsection (3).*—(Kim Leadbeater.)*

See the statement for Amendment 188.

Clause 28, as amended, ordered to stand part of the Bill.

Clause 29

INQUESTS, DEATH CERTIFICATION ETC

Danny Kruger: I beg to move amendment 522, in clause 29, page 17, line 14, leave out subsection (1).

In a letter to the editor of *The Telegraph*, the former chief coroner of England and Wales, Thomas Teague KC, wrote that clause 29

"would prohibit a coroner from investigating any death where the duty to do so arises only because the deceased died as a consequence of the provision of assistance in accordance with the Bill. But for that clause, the coroner would be under a statutory duty to investigate such a death and, if satisfied at inquest that the deceased had used an approved lethal substance to end his or her life with the intention of doing so, would be obliged to record a conclusion of suicide.

Since the coroner's jurisdiction affords a powerful deterrent against misfeasance, the public may wonder why the Bill proposes to abandon such a robust safeguard. The approval of the High Court is no substitute as it would be given in advance of death and could offer no assurance"

—we have scrapped the approval of the High Court, but it would have been no substitute, and it will be the same for the panel system—

"that the assistance had been provided in strict compliance with the law or that the circumstances of the case had not changed following the court's declaration.

If the Bill becomes law, who will provide the necessary posthumous judicial scrutiny of these unnatural deaths?"

That is a powerful suggestion from the former chief coroner.

6.15 pm

My amendment seeks to reverse the situation in the Bill, to ensure that there is a proper referral to the coroner and that the death is recorded as suicide. I can imagine three possible objections to that. The first is that it was not the lethal substance that killed the person but their terminal illness—the point has often been made that they are dying anyway—but the rest of clause 29 essentially admits that that is not the case. The new section the clause inserts into the Births and Deaths Registration Act 1953 provides for the cause of death to be recorded as assisted death, along with a note of the terminal illness. That is a recognition that something else has happened to the patient, not just the illness that they were dying from naturally.

The second objection is that it is not suicide so should not be investigated as such. We have been over that ground frequently. I am afraid the fact that Bill amends the Suicide Act gives the game away on that.

The third objection is that it is unnecessary, or over-burdensome, to insist on this usual step in the event of suicide. Given the concerns that have been expressed about this legislation, I agree with the former chief coroner that there ought to be some posthumous judicial scrutiny, especially as we have now removed the pre-death judicial scrutiny in the form of the High Court judge.

I will not cite the evidence we received from witnesses who have objected to the clause and who support my amendment—including the Centre for Women's Justice—but I note that some supporters of assisted dying have written to us with concerns about the clause. We heard oral evidence from Professor Ahmedzai, a strong supporter of assisted dying, and he told us in written evidence that deaths from assisted dying should automatically

"be referred to the local medical examiner, and if that professional has any reason to doubt that the procedures were not followed, there should be an automatic referral to the coroner."

Kim Leadbeater: That is indeed what would happen under the Bill as it stands.

Danny Kruger: The concern is that it should be automatic. I just cite Professor Ahmedzai's recognition of the frequent necessity, or the distinct possibility, of a referral to the coroner being appropriate. I suggest that it should happen as a matter of course. I would be grateful to understand from the hon. Lady or the Minister under what circumstances they feel it would be appropriate for a coroner to be involved. The difficulty is that we are putting a lot of emphasis on the role of the local medical examiner to decide whether it should be appropriate for the coroner to consider a case; I suggest that they should consider all cases.

The obligation on coroners need not be over-burdensome. Some coroner's inquests can be dealt with in as little as 20 minutes if matters are simple and not in dispute, which they would be in the great majority of the cases we are talking about. The presence of this jurisdiction—the ability of the coroner to investigate—would be a most valuable safeguard. It would help to identify whether matters have gone wrong in the act of self-administration and the process of dying, which could significantly assist whatever regulatory regime—we are yet to discover that—oversees the process. It could assist the continuous improvement of the regime.

It would also help to identify issues relating to misdiagnosis, which we know happens often. It is remarkable—and worth pointing out in response to the suggestion that terminal diagnoses are always accurate—that one study found, after autopsy, that one in four cases had been misdiagnosed. Doctors might say somebody is dying of a certain condition, but it turns out they were not.

I take the point that a coroner would not be prohibited by clause 29(1) from launching an investigation in appropriate cases, but given that we do not know what we do not know, it might be hard to decide when that is required. With a new scheme like this, it would be best to start with an investigation in every case. If, in a few years' time, it appears that the safeguard is not needed, a future Parliament could change the law to reduce it, but I implore the Committee to consider the idea that we should start with the safest Bill we can.

Sarah Sackman: Under the Coroners and Justice Act 2009, coroners have a duty to investigate and certify deaths that are reported to them. That duty is triggered when they have a reason to suspect that the deceased died a violent or unnatural death, the cause of death is unknown, or the deceased died while in custody or otherwise in state detention. There are also regulations made under the powers of the 2009 Act that require medical practitioners to notify such deaths to the coroner.

Clause 29(1) disapplies the coroner's duty to investigate in the case of an assisted death that has been carried out in accordance with the Bill's provisions. In practice, that would mean the assisted death would instead be certified by an attending practitioner—the doctor who has attended the patient—and scrutinised by an independent medical examiner working in the NHS. Therefore, the attending practitioner and medical examiner, rather than the coroner, would certify the cause of death. It would remain open to anyone—such as a family member or a medical practitioner who has interacted with the deceased and has concerns—to report a death to the coroner if they had concerns that it had not occurred in line with the provisions of the Bill.

Amendment 522 would remove the disapplication of the coroner's duty to investigate in relation to assisted deaths, essentially reversing the Bill's current provisions. Consequently, given that assisted deaths are inherently unnatural, the amendment would require that the coroner has a duty to investigate each and every assisted death and then certify the cause of death. To answer the hon. Member for East Wiltshire's point, the bereaved family would, as I have said, be able to raise any concerns with the medical examiner, and the coroner's duty to investigate would be triggered if they suspected that death had not occurred in line with the process prescribed.

It is important to note that medical examiners follow their own structured process of investigation. They review medical records, consult practitioners involved in the case and then apply the criteria set out from the Notification of Deaths Regulations 2019 to determine whether the death meets the threshold for a coroner referral. In doing so, they would proactively speak to family members, thereby providing the opportunity for any concerns to be raised; if there are any, they would make the referral to the coroner. I hope that assists the Committee.

Kim Leadbeater: I will be very brief. My understanding is—I think the Minister said this—that the attending practitioner, the medical examiner or anybody else, including family members, could refer to the coroner if they felt it was necessary or suspected anything untoward. If that is the case, I am content that the Bill is fit for purpose as it stands.

Danny Kruger: I will respond quickly. My concern is that, as Thomas Teague said, without clause 29 the coroner would be under a statutory duty to investigate. I recognise that there is an opportunity for an investigation if a family member or the medical practitioner decides to refer it to the coroner. It is unlikely—although they might—that the medical practitioner who has overseen the death would suggest that they themselves had somehow failed in their duty or that there had been a complication they could not have dealt with.

The fact is that the only way a coroner would get involved under the Bill as it stands is if they conclude that there is something wrong on the basis of not knowing what has happened, because they have not performed any investigation. The purpose behind the amendment is to ensure that there is a statutory duty for the coroner to review the death. It is also a point of principle that it is appropriate to record the death as suicide, because that is what has happened—assisted suicide. Nevertheless, given the state of the debate, and that I suspect I am not in the majority in supporting the amendment, I will not press it to a vote. I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Sarah Olney (Richmond Park) (LD): I beg to move amendment 273, in clause 29, page 17, line 33, at end insert—

"(1A) Regulations under subsection (1) must specify that the following information is collected for each assisted death—

(a) the person's age,

(b) the person's gender,

(c) the person's ethnicity,

(d) the postcode of the person's address at the time of their death,

(e) whether the person had a disability for the purposes of section 6 of the Equality Act 2010 (Disability), and

(f) any illness, disease or medical condition the person had that was deemed terminal for the purposes of section 2."

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

Amendment 274, in clause 34, page 20, line 43, at end insert—

"(2A) The Chief Medical Officer's report must include an analysis based on information—

(a) provided to them under section (Collection of information on assistance),

(b) information required by regulations made under section 39B of the Births and Deaths Registration Act 1953 (Regulations: assisted dying)."

This amendment is linked to Amendment 273 and NC10 and provides that the Chief Medical Officer's report must include an assessment/analysis of information received under that new clause.

New clause 10—*Collection of information on assistance*—

"(1) The coordinating doctor must, following the provision of assistance under section 18, record information on—

(a) how the process of providing assistance was carried out,

(b) the time taken from the ingestion or administration of the substance provided under section 18 to the time of death, and

(c) any complications or unforeseen circumstances that arose in connection with the ingestion or administration of the substance and how those were managed.

(2) The record created under subsection (1) must be made available to the relevant Chief Medical Officer.

(3) In this section 'coordinating doctor' includes a doctor authorised by the coordinating doctor to provide assistance under section 19."

This new clause provides that the coordinating doctor (or other doctor authorised to provide assistance) must collect certain information on the provision of that assistance.

Sarah Olney: It is a pleasure to serve under your chairmanship, Mrs Harris.

We have discussed throughout the course of the Committee the importance of collecting good information on the operation of assisted dying, and I know that hon. Members will agree that understanding the impact of legislation on society, for better or ill, helps us to improve its operation and respond to any urgent issues that arise. To this end, my amendments and new clause specify that a few more pieces of information must be recorded by the doctor who facilitates an assisted death.

Recording the method, the time taken and noting any complications is not overtly onerous on the co-ordinating doctor, and these three pieces of information could be crucial to uncovering which drugs are most appropriate. It will also enable us to understand more broadly whether those who have assisted deaths are having good deaths. It would be deeply unfortunate if we were to introduce a mechanism intended to help those likely to die in great pain or with indignity, only for that mechanism to offer some patients an alternative kind of painful death. One of the ways we can learn which methods of assisted death are the most humane is to make careful notes of any complications and the time taken to die.

It is also critical that we understand the wider social picture of this significant social change, in particular with regards to equality considerations. Are there groups who are excluded from assisted dying? Are there groups who are over-represented? Should we treat one group's over-representation as a demonstration of good access to the service, or should we see it as a failure elsewhere in the system? We can understand how those who face discrimination in our society are impacted by the Bill only if we collect this data, which is what my amendment proposes.

Dr Jamilla Hussain said that

"racism is also a specific issue within palliative care. We did a survey, post-covid, of staff across the nation working in palliative care. More than 1,400 people responded. The vast majority—more than 80%—were white British, but 40% said that they had witnessed or experienced racism within the end-of-life care sector. For ethnic minority groups, that is much higher. That leads to mistrust. I work in Bradford. We have lots of patients who are ethnically diverse in the hospital. Almost every week, one of the first things I have to reassure patients about is that I cannot legally do anything to shorten their life. This is front and centre of the fear for those patients and we see it all the time."—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee,* 29 January 2025; c. 190, Q247.]

As Dr Hussain highlighted there and at other points, racism exists in the palliative care sector. If we want to tackle discrimination, recording ethnicity and requiring the voluntary assisted dying commissioner to analyse the data would help.

Dr Sarah Cox told us:

"We need to make sure that there is not inequity in palliative care, so that you do not have to be white and rich and have cancer to get good palliative care."—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee,* 28 January 2025; c. 78, Q101.]

The consequence of failing on palliative care provision will lead to more people feeling they have no choice but to end their life early.

Collecting data would also help us to understand the legislation's impact on women. I am pleased that the Committee agreed to the amendments proposed by the hon. Member for Lowestoft concerning training on coercive control and domestic abuse. The amendment also highlights the intersection between misogyny and the abuse of assisted dying, about which the hon. Member for Bradford West has spoken so compellingly at different points. Understanding how the law affects and interacts with women in particular seems to me to be relevant and necessary. If we are to ensure that the law operates in a way that is good for women, we need to collect this data from patients.

Lewis Atkinson: I entirely agree with the hon. Member for Richmond Park and I absolutely expect this information to be collected. My observation, as ever, is that I do not think we should put the exact details in primary legislation. The powers are clearly there for the Secretary of State

to specify what information should be collected. I am struggling to find it, but I know that my hon. Friend the Member for Spen Valley will move an amendment to require the Secretary of State, when they make provisions and issues guidance under the Bill, to consult the Equality and Human Rights Commission and others in respect of protected characteristics.

Kim Leadbeater: I have been desperately trying to find the amendment number—I think it is amendment 500 that looks at what will be recorded, and it covers such data as the hon. Member for Richmond Park is requesting.

Lewis Atkinson: I agree that we need the data to ensure that we understand how assisted dying operates in relation to different protected characteristics and geographical distribution, but I am not sure that amendment 273 is the way to do that.

6.30 pm

Naz Shah: I was not intending to speak to this group, but I am now trying to find amendment 500.

Kit Malthouse: Amendment 500 was to clause 21 and we have agreed it already.

Naz Shah: In responding to my hon. Friend the Member for Sunderland Central, I appreciate that we do not want to put too much detail in the Bill, but with some of the commitments that we have made as a Government on collecting data we need to go further. That is for the simple reason that our equality laws are not right when we look at other issues, such as the gender pay gap.

The Chair: Order. Can we stick to the amendment that we are debating?

Naz Shah: Amendment 273 would strengthen our position to collect that data, which is really important if we are serious about potentially reviewing the legislation by looking at the loopholes and at which communities are taking up assisted dying. The data in other jurisdictions says that it would be people from affluent backgrounds, but the hon. Member for Richmond Park powerfully raised concerns about the risks, as we heard in evidence from people such as Dr Jamilla and others. I strongly support the amendment, but I will also look at the Equality and Human Rights Commission issues that my hon. Friend the Member for Sunderland Central raised; I thank him for raising them.

Lewis Atkinson: Does my hon. Friend agree that to keep the list of characteristics on which we have to collect information up to date, we need a level of flexibility—not in primary legislation? Would she comment on the fact that no information regarding sexuality or other protected characteristics is included in the Bill?

Naz Shah: My hon. Friend makes a valid point; that is an issue. If we are going to do this right, are we going to be looking at all six characteristics? That is important, so I agree with him.

Daniel Francis (Bexleyheath and Crayford) (Lab): It is a pleasure to serve under your chairship, Mrs Harris. I was also not intending to speak, but I think there are two slightly different issues here. Prior to Second Reading, the Equality and Human Rights Commission produced a briefing paper on some of the issues that have been covered in amendment 500. It also gave oral evidence where it was not happy about some aspects of the Bill and about not having the equality impact assessment.

I hear what my hon. Friend the Member for Sunderland Central says, but the briefing that the EHRC produced—although I appreciate what the Equality Act says—did not talk about sexuality, for instance, but it did talk about many of the aspects that are in the amendment of the hon. Member for Richmond Park. In the oral evidence, Dan Scorer from Mencap particularly talked about the experience in covid—for example, someone was five times more likely to have a do not resuscitate order placed on them if they have a learning disability. There is wide evidence of that, as Members, and me in particular, were well aware before we heard that oral evidence.

As a councillor, I remember the experience of ethnic minority communities during that period. I used to represent a council ward with a high west African population. There were clear cultural issues around people's experiences with the health service during that period, and whether they wanted to take up the vaccine. As the then leader of the opposition on my council, I had regular meetings about the different levels of uptake of health services among different communities.

Beyond new clause 8, tabled by my hon. Friend the Member for Spen Valley, which would require the Secretary of State to engage with the Equality and Human Rights Commission, there is a valuable reason for seeking to have that data and for ensuring that the assisted dying commissioner has that data. As I will talk about in debates on subsequent groupings, Dan Scorer from Mencap clearly asked about what happens if things go wrong for people with certain protected characteristics, and at what stage we will review that.

Some of us have legitimate concerns about the characteristics in the amendment tabled by hon. Member for Richmond Park, and about coercion, particularly of women. People have listened long and hard about where I am coming from on this issue, and unlike some other Committee members, I am not opposed to assisted dying per se. I have come to the position, however, that it is vital to try to capture the data on people with learning disabilities or for whom there is a judgment about their level of mental capacity, and that should be in the Bill. I therefore support the amendment.

Jack Abbott (Ipswich) (Lab/Co-op): It is a pleasure to serve under your chairmanship, Mrs Harris. I was not planning to speak on this group either, but the debate speaks to a number of the things that we have talked about in the past few weeks. I add the caveat that all hon. Members present acknowledge that the promoter of the Bill, my hon. Friend the Member for Spen Valley, has repeatedly made it clear that data collection is essential to what we are proposing. I am also sympathetic to what my hon. Friend the Member for Sunderland Central said about not necessarily needing to put everything in the Bill.

[Jack Abbott]

Without trying to sound like a broken record, however—I have made this point several times over the past few weeks—it is critical that in certain situations, although there may be some regulations or inferences that exist that may lead to certain outcomes that we on this Committee would all like to see, there is nothing necessarily wrong with putting them explicitly in writing.

Hon. Members have used different stats from different jurisdictions in their own way to lend weight to their arguments, and although many of those stats are relatively consistent in a number of areas, they are not necessarily decisive. I cited a stat yesterday when speaking to an amendment that around 10% of people using the assisted dying route have complications during the final stages, but as I said then, that came from an incredibly small sample size of just over 100 people.

It is therefore critical that, if the Bill is passed and we go down this path, we pursue robust and expansive data gathering in a number of different areas, and I am sure that any Government would look to do so. As long as it does not create any loopholes or unintended consequences, that sort of evidence gathering should be in the Bill because, at the very least, that would provide reassurance that it will happen if the Bill is passed.

Sarah Sackman: I do not have a lot to add, but I point out that, as the Bill stands, clause 34 requires the chief medical officer to, among other things, submit an annual report to the relevant national authority on the operation of the Act. Amendment 382 tabled by my hon. Friend the Member for Spen Valley would make the voluntary assisted dying commissioner responsible for that function instead. Amendment 274 would require that the report under clause 34 contains an analysis of the additional information to be collected under new clause 10 and amendment 273. I remind the Committee of that because we are discussing what information should be gathered, and at what point in the process. There is then the monitoring, reporting and co-ordinating function performed by the voluntary assisted dying commissioner, should those later amendments be passed.

Kit Malthouse: My assumption is that once a commissioner is appointed, and in drawing up the regulations and guidelines for reporting, there will be consultation between the Government and the commissioner about what the commissioner actually wants to report on. From what the Minister is saying, I assume that, unless we collect the data, the commissioner will have nothing to say in their report.

Sarah Sackman: I thank the right hon. Gentleman for that intervention, and that is exactly why I made that point. One of the design features of the commissioner model is the monitoring function, through which they will undertake annual reporting and an assessment of patterns in the practice, should the legal regime come into force. That is exactly how I anticipate it working.

The commissioner can also be self-correcting and say, "We need to see more information on this because it is a concern. We have this equalities data"—or whatever data we have collected—"and we need to see more on this aspect, because this pattern is a concern to us or it would help to illuminate how the practice is operating." That is all I wanted to add, because one has to appreciate the operation of the regime as a whole.

Kim Leadbeater: As has been alluded to by various Committee members, I fully support the intention behind amendment 273, but I think it will be covered already. I have mentioned my amendment 500, but amendment 455 is probably more pertinent. It looks at the annual report that the assisted dying commissioner would produce, which makes reference to protected characteristics, and sets out that any other such data can and should be collected under regulations.

I am therefore confident that that report would encompass the points made by amendment 273, and that reference is made to the analysis that is covered by amendment 274. I feel confident that the intention will be met by the introduction of the voluntary assisted dying commissioner, but I wholeheartedly agree that data collection is a fundamentally important part of the process.

Sarah Olney: I want to make a couple of further points in response to some of the those raised by Members. First, I have looked at amendment 500, which the hon. Member for Spen Valley directed me to, and I thank the hon. Member for Reigate for showing it to me—her record keeping is much better than mine. I was going to say that amendment 500 does not cover a lot of the areas that I have raised, but the hon. Member for Spen Valley has just referred me to amendment 455.

However, it is important to say that amendment 455 refers only to "protected characteristics" under the Equality Act 2010. I specified particular characteristics in amendment 273 in response to some of the evidence that we received. In particular, I included the person's age in response to evidence that we received from Together for Short Lives, which represents children's hospices including Shooting Star in Richmond. It had specific concerns about the issue of assisted death being raised with young people under 18, and that is why I specified that. I also included gender and ethnicity, which I mentioned earlier, and that came through very strongly in a lot of the oral evidence that we received.

To address the point made by the hon. Member for Sunderland Central, I did not hear sexuality being raised as a risk factor at any point. Obviously, members of the LGBTQ+ community experience a great deal of discrimination, but I have not heard it raised as a specific risk factor for assisted dying, which is why it is not on the list. I have included the person's postcode because I do not know a better way of assessing whether someone is from a low-income background. I particularly draw the attention of hon. Member for Spen Valley to that characteristic, because it is obviously not protected under the Equality Act, so I remain really concerned.

Dr Marie Tidball (Penistone and Stocksbridge) (Lab): For the avoidance of doubt, socioeconomic status would have been a protected characteristic under the Equality Act, were it not for the previous Conservative Government.

Sarah Olney: I thank the hon. Lady for that useful intervention. As I say, socioeconomic status is not currently a protected characteristic under the Equality Act.

Danny Kruger: I think the hon. Member for Penistone and Stocksbridge meant the previous Conservative and Liberal Democrat Government—just to be strictly accurate.

Sarah Olney: I expect the hon. Lady did, but since none of us in the room was a member of that Government—I think—or indeed Members of Parliament at the time, I do not know how hon. Members want me to respond to that. It remains the case, I believe, that socioeconomic status is not currently a protected characteristic under the Equality Act. If anyone wants to reopen that debate, I am sure there would be an appetite for it.

6.45 pm

Kit Malthouse: Obviously the hon. Lady is a London MP, but I gently point out that particularly in a London context—and in other urban areas—someone's postcode is actually a very poor indicator of socioeconomic status. I represented central London as a London Assembly member for eight years and, in large parts of central London, there is social housing in the same postcode as extremely expensive houses running into the many millions.

Sarah Olney: I know: the Barnes ward in my constituency is one of the most unequal wards in the country, so I fully appreciate the right hon. Gentleman's point. As I say, that is the socioeconomic indicator that I have for now, thanks to the failings of our predecessors to include it in the Equality Act, but I am open to amendments on Report if anybody has something more compelling. I do think that it really matters that we look at the socioeconomic status of people who are seeking an assisted death, and I welcome feedback—and, as I say, further amendments—on how that particular part of clause 29 could be improved.

Lastly, I included whether someone has a disability, which obviously has come up many times in the written and oral evidence. That is why I specified those characteristics in response to the evidence that we received, and why I am keen to press amendment 273 to a vote.

Amendment 273 agreed to.

Danny Kruger: I beg to move amendment 446, in clause 29, page 18, line 9, at end insert—

"(4) The Secretary of State must, by regulation, specify the data sets which must be made available by the Registrar General for England and Wales.

(5) Any regulations made under subsection (4) are subject to the affirmative procedure."

This amendment requires the Secretary of State to specify in regulations the data sets which are to be made available by the Registrar General for England and Wales.

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

Amendment 486, in clause 29, page 18, line 9, at end insert—

"(4) A report provided under subsection (3) must include statistical analysis of—

(a) demographic information relating to those who have received assistance under the Act, including breakdowns by the protected characteristics defined under section 4 of the Equality Act 2010;

(b) the length of time between the taking of approved substances and the time of death; and

(c) any complications that occurred as a result of the administration of a substance under the provisions of this Act."

This amendment determines the data to be collated in the reports of the Registrar General.

Clause stand part.

Danny Kruger: These amendments were tabled by the hon. Member for York Central. As discussed, clause 29 requires the Registrar General to

"prepare and lay before Parliament a report providing a statistical analysis of deaths"

arising. We have spoken before about the paucity of data from other jurisdictions and the problems arising when data is not collected from the start; when data is collected only in relation to one thing, such as disability in Canada; when data collection is suddenly discontinued, as in Washington state as I understand it; or when data is insufficiently granular, so that we get only the headlines. I therefore think that this approach is valuable, and I welcome the Committee's decision to support amendment 273 tabled by the hon. Member for Richmond Park. Amendments 446 and 486 would ensure that we fix those problems from the start.

Amendment 446 would give the Secretary of State the power to specify the datasets that must be made available, and those must be approved by Parliament. MPs would then be able to interrogate what data we are collecting and what questions that enables us to answer. Ensuring that that is determined by regulation places it in law, and ensures ministerial responsibility and parliamentary oversight.

Amendment 486 sets out the data that must be included. That includes demographic information, including breakdowns by protected characteristics—and I acknowledge the conversation that has just been had on that topic—and the length of time between the taking of the approved substances and the time of death. It strikes me that that is a very important consideration. I hope that that would be specified in the data that the Registrar General will provide, but that is not clear at the moment. It is also vital that any complications are properly reported—not just recorded, but reported.

I do not propose to push these amendments to a vote; I think that the argument has been sufficiently made. I am grateful to the Committee for supporting the previous amendment. However, I wish that things were otherwise and that we were specifying more clearly what data will be collected. I hope that perhaps this debate will encourage the Registrar General to ensure that the most comprehensive data is presented to Parliament.

Sarah Sackman: In light of the hon. Gentleman's remarks, I do not have anything further to add, other than to note what he has said.

Kim Leadbeater: I have nothing to add.

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

Amendment, by leave, withdrawn.

Clause 29, as amended, ordered to stand part of the Bill.

Clause 30

CODES OF PRACTICE

Naz Shah: I beg to move amendment 447, in clause 30, page 18, line 12, leave out "may" and insert "must".

This amendment requires the Secretary of State to issue Codes of Conduct.

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

Amendment 394, in clause 30, page 18, line 24, at end insert—

"(ba) the provision of information and support to persons with learning disabilities who are eligible to request assistance to end their own life under this Act, including the role of advocates for such persons;"

Amendment 448, in clause 30, page 18, line 27, after "of" insert "registered and qualified".

This amendment requires a code of practice on the use of interpreters to be, instead, on the use of "registered and qualified" interpreters.

Amendment 534, in clause 30, page 18, line 30, at end insert—

"(da) the forms of proof of identity that are acceptable for the purposes of section 6."

Amendment 523, in clause 30, page 18, line 31, leave out paragraph (e) and insert—

"(1A) The Secretary of State may issue one or more codes of codes of practice in connection with any matters relating to the operation of this Act not required under subsection (1) as the Secretary of State considers appropriate."

This amendment, which works together with Amendment 447, would clarify that the Secretary of State is not required to issue a code of practice under subsection (1)(e) but instead has the discretionary power to issue further codes of practice as the Secretary of State considers appropriate.

Naz Shah: Amendment 447 was tabled by my hon. Friend the Member for York Central; I also speak in support of amendment 523, which was tabled by the hon. Member for East Wiltshire and helpfully clarifies amendment 447. My understanding was that the Bill's promoter indicated that this was something she would support; I am happy to give way so she can clarify.

Kim Leadbeater: I confirm that I am happy to support amendment 447.

Naz Shah: Perfect. I thank my hon. Friend—I like it when we get to amendments that are supported.

Amendment 447 would literally change the word "may" to "must" in clause 30. The first four matters that the clause lists are so important that issuing codes of practice cannot be left just as a choice for the Secretary of State; it must be something that the Secretary of State has to do. It is worth pointing out, as I am learning about this new process, that when we leave it to the Secretary of State, that means a Secretary of State under any Government, depending on how long it takes. It is not necessarily just our Government; it could be another Government. I am just pointing that out, because somebody pointed it out very clearly to me, and I was shocked by that detail.

The Bill sets out five areas of responsibility that the codes could cover. They include some of the most consequential matters that this Committee is considering, as set out in clause 30. The first four are doctor's assessments of

"whether a person has a clear and settled intention to end their own life,"

and whether that person has capacity to do so, accounting for the effect of depression and other mental disorders on decision making; the

"treatment or palliative, hospice or other care available to the person";

the provisions for effectively communicating with them; and

"the arrangements for providing approved substances to the person… and the assistance which such a person may be given".

They are all vital and I am pleased that this amendment would ensure that the Secretary of State has to issue codes of conduct, rather than being able to decide that they may not do so.

If these matters were not covered by codes of practice, they could be left to individual doctors to interpret, which would mean that doctors would face having to make unfamiliar and complex decisions without the clear guidance that a code of practice would give. That could have created—indeed, it would have created—dangers for both doctors and for people seeking assisted dying.

The fifth area of responsibility for the Secretary of State, as set out in clause 30, is codes of practice on:

"such other matters relating to the operation of this Act as the Secretary of State considers appropriate."

It seems clear to me that, because the Secretary of State will issue codes of practice for the first four areas of responsibility, they must also issue codes for other matters if they see a need for them. I am confident that we all agree on that.

Amendment 523 would make it clear that the Secretary of State can issue codes of practice on any other matters as they see appropriate, but they would not have to do so if they thought there were no other matters that needed such codes. That is a sensible clarification that preserves what the Bill drafters were doing when they wrote the clause. If the Bill passes, we will be authorising doctors to depart from centuries of previous practice. They will face decisions that they have not previously had to take. I am pleased that, if the Bill passes, the Government will be able to set out the clearest possible guidelines for medical professionals in accordance with the many provisions in this clause.

Doctors in England and Wales have never previously had to assess whether someone has a clear and settled intention, and it is surely unfair to ask them to work out how to make that judgment without clear guidance from a code of practice. A code of practice also mitigates the risk that different doctors will approach this task in widely differing ways. The truth is that the use of the Mental Capacity Act 2005 is untested in relation to assisted death, where a person will take lethal drugs to end their life.

Codes of practice will address important and difficult questions of interpretation. Again, that will give us much-needed clarity, including in the area of the provision of palliative care to people considering assisted dying and how doctors advise them. The independent commission on palliative and end of life care found that knowledge

of palliative care among doctors is often limited, so the Secretary of State's intervention will be much appreciated, and the codes will give a settled direction.

I am grateful that my hon. Friend the Member for Spen Valley has accepted amendment 447. I look forward to working through the rest of the Bill and getting some more amendments passed.

Daniel Francis: I will speak to amendment 394 in my name, which provides that codes of practice may be issued on

"the provision of information and support to persons with learning disabilities who are eligible to request assistance to end their own life under this Act, including the role of advocates for such persons".

I am aware that my hon. Friend the Member for Spen Valley may speak to amendment 517 and new clause 25, which we will discuss shortly.

I tabled a number of amendments, one of which was accepted, following conversations with Mencap. Dan Scorer from Mencap gave us oral evidence on advocacy support, the discussions and the role of families and said:

"Individuals should be able to choose who supports them with those discussions, whether it is friends or family members or an independent advocate—that would probably be our preference—who is specifically trained to support people with a learning disability who are considering their end-of-life options."—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee,* 30 January 2025; c. 273, Q355.]

I will not go on at great length—hon. Members have heard my views on support for people with learning disabilities, and I am conscious that we will come to other amendments on this issue—but I will move my amendment when we get to the relevant stage, in a manner consistent with the approach that I have taken in Committee so far.

Jack Abbott: I realise that we could be called away to vote at any moment, but I rise to speak to amendment 534. It is relatively small, and I appreciate that what it seeks may already be covered by regulations, but it would ensure that it is also put in a code of practice.

Anybody seeking an assisted death under the Bill who meets the eligibility criteria should be able to access it. However, there is a risk that the requirement that patients provide two forms of proof of identification could present challenges for certain groups, causing inequalities of access—*[Interruption.]*

The Chair: Order. The sitting is suspended for 15 minutes for a Division in the Chamber. The Committee will reconvene at 7.15 pm.

7 pm

Sitting suspended for a Division in the House.

7.15 pm

On resuming—

Jack Abbott: We all know that inequitable access to good quality health and palliative care is a massive issue across the country. People in certain communities—for example, those living in areas of high deprivation, those from black, Asian and minority ethnic communities and those from inclusion health groups, such as the homeless—already experience significant challenges in accessing quality care.

We have a duty to ensure that anyone meeting the eligibility criteria who wishes to seek an assisted death under the Bill can do so. We must therefore ensure that the requirements for which forms of proof of identity are acceptable do not exacerbate existing inequalities of access and prevent those who would otherwise meet the eligibility criteria from seeking an assisted death should they choose to.

The question of which forms of proof of identity are acceptable is therefore essential, as we know that photo ID requirements can present additional barriers to certain demographics and communities. Data from the Electoral Commission following the 2023 local elections found that while only 3% of all non-voters said that they did not vote because they did not have the required ID, that figure was 8% for unemployed non-voters and 9% for disabled non-voters who reported being "limited a lot" by their disability or health condition.

The data also found that awareness of ID requirements was lower among those without an accepted form of ID—only 74%, in contrast with 92% of the population overall. Awareness of the requirement was also lower among young people and those from black and ethnic minority communities. Clearly, a photo ID requirement could present barriers to equitable access to assisted dying. We must ensure that requirements about which forms of proof of identity are acceptable do not create new inequalities of access.

The requirement for proof of identity has been included in the Bill for a good reason, because it is a necessity and a critical safeguard. Ensuring that the Bill has the requisite safeguards for assisted dying to be safely implemented is essential to what the Committee is doing. It is therefore important to get right the question of what forms of proof of identity are acceptable for someone to access assisted dying under the Bill. We must also ensure equity of access to the service without diluting critical safeguards.

Clause 6 says that the regulations regarding the forms of proof of identity that are acceptable are subject to the negative procedure, but the issue is too important to be left to that negative procedure without sufficient parliamentary scrutiny. By including the requirements for which forms of proof of identity are acceptable in clause 30, the amendment would rectify that. It would entail that the regulations pertaining to which forms of proof of identity are acceptable under clause 6 are subject to the affirmative procedure and that, prior to the Secretary of State issuing a code of practice in relation to the question, they would have to consult such persons as they considered appropriate.

By agreeing the amendment, we would guarantee that the question of which forms of proof of identity are acceptable is given the requisite consideration. That would ensure that the requirements do not act as a barrier to equitable access to assisted dying, without diluting the safeguards that the requirement inserts into the Bill.

Danny Kruger: I want to quickly explain that my amendment 523 is consequential on amendment 447, but there is drafting issue. I will not go into the details

[Danny Kruger]

but, if amendment 447 is made, as I understand it will be, my amendment 523 is not necessary. I would be grateful for the Minister's guidance: if he has been advised by parliamentary counsel that the clause as amended by amendment 447 is okay and there is no need for amendment 523, I do not propose to press it to a vote.

Stephen Kinnock: This group of amendments relates to clause 30 of the Bill and the codes of practice that may be issued by the Secretary of State.

As the Bill is drafted, the Secretary of State may issue one or more codes of practice in connection with arrangements pertinent to the assisted dying process. Amendment 447 requires the Secretary of State to issue such codes, substituting "must" for "may". As such, codes of practice would need to be issued for all matters listed in clause 30(1).

Amendment 394 has the effect of broadening to Secretary of State's power to issue codes of practice, explicitly enabling the Secretary of State to issue guidance in connection with

"information and support to persons with learning disabilities who are eligible to request assistance"

under the Bill, including information and support about the role of advocates. I note that under the Equality Act 2010, health providers are already under a duty to make reasonable adjustments in the provision of services, including for persons with a learning disability. That duty includes taking steps to provide information, including on what support services are available.

As drafted, clause 30(1)(c) provides that the Secretary of State may issue codes of practice on

"the arrangements for ensuring effective communication in connection with the provision of assistance…including the use of interpreters".

Amendment 448 provides that, if the Secretary of State issues codes of practice that include the use of interpreters, those interpreters should be "registered and qualified". The amendment would limit those who are able to translate to only those who are registered and have a recognised qualification. However, the amendment does not state who or what such a registration would be with, or what would constitute a recognised and appropriate level of qualification.

Amendment 534 adds to the list of codes of practice that the Secretary of State may issue. The addition is a code of practice on the acceptable forms of proof of identity when a person makes a first declaration. Clause 6(3) of the Bill already provides a regulation-making power that sets out the acceptable forms of proof of identity. Amendment 534 would give the Secretary of State a power to make codes of practice about how someone can ensure they are compliant with the requirements set out under clause 6(3). The amendment has little practical effect, because clause 30(1)(e) already provides a wide power for issuing codes of practice, providing that the Secretary of State may issue codes of practice on

"such other matters relating to the operation of this Act as the Secretary of State considers appropriate."

Amendment 523 allows the Secretary of State to issue further codes of practice at his discretion, should they not be covered by the preceding subsection (1) of this clause. The Bill's promoter has said she is minded to support amendment 447, and the hon. Member for East Wiltshire asks whether, if amendment 447 is incorporated into the Bill, that renders amendment 523 unnecessary or surplus to requirements. I am not entirely sure, so I will quickly check while the Bill's promoter is making her remarks and come back to him immediately.

Kim Leadbeater: I thought we were going to get a full house with this group, but let us have a look. I am minded to support amendment 447, as I have previously said. I will wait to hear from the Minister the impact that that will have on amendment 523.

Stephen Kinnock: I can confirm that amendment 523 is a helpful amendment as 447 is incorporated, so that is all fine—we are good with that.

Kim Leadbeater: That is very helpful indeed. In that case I am very pleased to support amendment 523 in the name of the hon. Member for East Wiltshire as well. I am also minded to support amendment 394 in the name of my hon. Friend the Member for Bexleyheath and Crayford, which I think is very sensible, like his other amendments that I have supported. I am not sure that amendment 534 in the name of my hon. Friend the Member for Ipswich is entirely necessary, but I fully understand the sentiment and therefore I am minded to support that amendment as well.

That brings me on to the final amendment, 448. I wanted to support this amendment, but I have taken on board the Minister's comments on the lack of clarity about what it means to be registered and qualified. As such, I cannot support that amendment this evening, but I think we could look at coming up with something on Report that would achieve the objective that my hon. Friend the Member for York Central intended.

Amendment 447 agreed to.

Amendment made: 394, in clause 30, page 18, line 24, at end insert—

"(ba) the provision of information and support to persons with learning disabilities who are eligible to request assistance to end their own life under this Act, including the role of advocates for such persons;"—*(Daniel Francis.)*

Amendment made: 416, in clause 30, page 18, line 25, leave out paragraph (c).—*(Jack Abbott.)*

This amendment is linked to Amendment 417.

Amendment made: 430, in clause 30, page 18, line 30, at end insert—

"(da) responding to unexpected complications that arise in relation to the administration of the approved substance under section 18, including when the procedure fails;".—*(Daniel Francis.)*

Dr Tidball: I beg to move amendment 517, in clause 30, page 18, line 30, at end insert—

"(da) arrangements for a qualifying person requesting assistance to end their own life to receive the support of an independent advocate under section [*Independent advocate*]."

This amendment would add arrangements for a qualifying person to receive the support of an independent advocate (NC25) to the list of matters that codes of practice may be issued on.

The Chair: With this it will be convenient to discuss new clause 25—*Independent advocate*—

"(1) The Secretary of State must by regulations make provision as to the appointment of persons as independent advocates.

(2) The regulations may, in particular, provide—

(a) that a person may act as an independent advocate only in such circumstances, or only subject to such conditions, as may be specified in the regulations;

(b) for the appointment of a person as an independent advocate to be subject to approval in accordance with the regulations;

(c) persons that may appoint independent advocates;

(d) provision for payments to be made to, or in relation to, persons carrying out the function of an independent advocate under this section;

(e) training that such advocates must undertake before being appointable; and

(f) obligations on persons performing functions on this Act to ensure the presence of an independent advocate for a qualifying person.

(3) The role of independent advocates is to provide support and advocacy to a qualifying person who is seeking to understand options around end of life care, including the possibility of requesting assistance to end their own life, to enable them to effectively understand and engage with all the provisions of this Act.

(4) For the purposes of subsection (2) a person is a 'Qualifying person' if they—

(a) have—

(i) a learning disability;

(ii) a mental disorder under section 1 of the Mental Health Act 1983; or

(iii) autism; or

(b) they may experience substantial difficulty in understanding the processes or information relevant to those processes or communicating their views, wishes or feelings; or

(c) they meet criteria that the Secretary of State may specify by regulations.

(5) Regulations may not be made under this section unless a draft of the statutory instrument containing them has been laid before and approved by a resolution of each House of Parliament."

This new clause would require the Secretary of State to, by regulations, make provision for independent advocates to provide assistance to qualifying persons.

Dr Tidball: It is a pleasure to serve under your chairship, Mrs Harris. I rise to speak to my new clause 25 and my related amendment 517. I note with pleasure that the Committee has agreed to amendment 447, which mandates the need for the code of practice. I also support amendment 394, tabled by my hon. Friend the Member for Bexleyheath and Crayford.

My new clause 25 would require the Secretary of State to make provision by regulations for independent advocates to provide assistance to qualifying persons under the Bill. Amendment 517 would add

"arrangements for a qualifying person…to receive the support of an independent advocate"

to the list of matters provided for by the codes of practice in clause 30.

The issue is deeply important to me. On Second Reading, I said:

"so often control is taken away from disabled people in all sorts of circumstances.

In order to ensure that there is compassionate choice at the end of life, it is right that the Bill is tightly drawn around the final stage of terminal illness for adults and includes the strongest safeguards."—[*Official Report*, 29 November 2024; Vol. 757, c.1052.]

Those safeguards must include strengthening the voices of disabled people, both in the Bill and in the monitoring of its impact on disabled people if it is ultimately enacted. I tabled new clause 25 and the related amendment 517 alongside my proposed new clause 27, which would mandate a disability programme board to strengthen disabled people's voices, empowering and better enabling them to be treated with dignity and respect when they are a qualifying person seeking to understand their options around end-of-life care.

Subsection (3) of new clause 25 states:

"The role of independent advocates is to provide support and advocacy to a qualifying person who is seeking to understand options around end of life care, including the possibility of requesting assistance to end their own life, to enable them to effectively understand and engage with all the provisions of this Act."

During one of the Committee's oral evidence sessions, Professor Tom Shakespeare—the leading disability scholar and public policy expert—was asked which of the Bill's measures could be strengthened to further protect disabled people. He said:

"We could have more of an advocate for the person who is requesting assisted dying—somebody who will support them, within the law, to make that decision or to think about their decision."—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee,* 29 January 2025; c.144, Q181.]

My new clause responds to the evidence from witnesses during those sessions and augments proposals made by my hon. Friend the Member for Bexleyheath and Crayford. It extends those proposals in two ways. Under the new clause, "qualifying person" would include those with a learning disability, those with autism and, importantly, those who have a mental disorder under section 1 of the Mental Health Act 1983. It also extends the scope to cover those who, as set out in subsection (4),

"may experience substantial difficulty in understanding the processes or information relevant to those processes or communicating their views, wishes or feelings; or…meet criteria that the Secretary of State may specify by regulations."

7.30 pm

Secondly, the new clause sets out in more detail the establishment of an independent advocacy role. In particular, subsection (2) makes provision

"for payments to be made to, or in relation to, persons carrying out the function of an independent advocate under this section;…training that such advocates must undertake before being appointable; and…obligations on persons performing functions on this Act to ensure the presence of an independent advocate for a qualifying person."

I am very grateful for Mencap's feedback on my amendment and new clause, and that of Yogi Amin, who has decades of experience as a Court of Protection, mental capacity and equality lawyer. During the Committee's oral evidence sessions, Dan Scorer from Mencap talked about the need to ensure that rights to advocacy begin at the very start of the process, including at the initial conversation with the medical practitioner, so that terminally ill people with a learning disability are fully prepared for and supported in that discussion. He emphasised the importance of preparing people for and supporting them in such discussions. Mencap therefore wanted a right to advocacy to be included in the Bill to support people considering their end-of-life options.

I have worked to ensure that my amendment 517 and new clause 25 would insert a strong model of independent advocacy in the Bill. Crucially, that is reinforced by subsection (2)(e) of the new clause, which states that such advocates must undertake training before their appointment.

Read in conjunction with amendment 394, in the name of my hon. Friend the Member for Bexleyheath and Crayford, amendment 517 and new clause 25 are a vehicle for integrating into this Bill the use of the NHS accessible information standard, about rights to information and support for disabled patients, for qualifying people. That would address one of the other important requests that Mencap raised in its evidence. For those reasons, I commend the new clause and amendment to the Committee.

Daniel Francis: We are in danger of having much consensus this evening. As hon. Members know, this issue is very close to my heart, and my hon. Friend the Member for Penistone and Stocksbridge knows more than anybody that inequality for disabled people in this country remains ingrained. As the parent of someone with a very complex set of disabilities, including a learning disability, I have seen that at first hand.

I welcome new clause 25 and amendment 517, in the name of my hon. Friend. My concern with the Bill is that we must protect vulnerable people, particularly those with learning disabilities, and the amendment and new clause would address some of my concerns by providing an independent advocate, as Mencap asked for, in circumstances that the Secretary of State would specify. I welcome the fact that, as my hon. Friend said, the amendment and new clause join my amendment 394 in making that happen. The proposal includes people who have substantial difficulty in understanding the process or the information involved, or in communicating. I note that the specified conditions could include a wide range of people, and I thank my hon. Friend for including them.

In due course, we will see what circumstances are dealt with in regulation. There are two issues that I have raised throughout this debate, and they remain a tension. One is that we must support people with learning disabilities and the other is capacity. We need to be very clear about that in the training, and I trust that that will be dealt with in due course. Advocates must not be seen as leading people into decision making, as they could be under the Mental Capacity Act 2005, which gives them that scope. We need to be clear in the training that they have to assist the person in making their decision. I will be supporting these proposals, because I am confident that we can overcome that in the training.

In her written evidence, Patricia Cook talked about decision making for her daughter who has Down's syndrome. She wrote:

> "My daughter has the mental capacity to make decisions about her daily routine, social, educational, and family matters, but she lacks the capacity to manage other aspects of her life such as her financial affairs and healthcare."

She went on:

> "My daughter is much more likely to defer to a clinician's proposal as she might think that she ought to agree."

We heard that important point again in oral evidence. I would hope that the advocate would be in a position to provide support and advocacy to a person having to make that decision.

Dr Tidball: I take on board and appreciate my hon. Friend's point. I hope he will agree that subsection (3) emphasises the purpose of the new clause, which is that it should apply across the spectrum of access to assistance and enable people to effectively understand and engage with all of the provisions in the Bill. I very much wanted to ensure that it would apply and be accessible at every stage.

Daniel Francis: My hon. Friend knows my concerns but she knows that I will be supporting the amendment this evening.

Advocates must have an understanding of the available end-of-life options and be able to communicate clearly and explain to patients the medical treatments available: palliative care, social care and assisted death. That is quite complex. As I have said previously, my own experience of mental capacity relates to my daughter: she would never have the capacity to be able to make such a decision. But on a daily basis, including this morning, I have to explain a two or three-point decision-making process. It is vital that advocates are there and that they have the training.

For many people such as my daughter, who is almost blind as well as being learning disabled, there are additional communication skills given that they have those extra sensory difficulties. It is vital for people such as Mrs Cook's daughter, who might be vulnerable to influence, that the advocate must be able to explain all the options clearly without pressurising the person down one route. I believe the amendment will provide important support to those with less capacity or difficulty in understanding all the options in front of them.

As I have said, the two things that I have banged on about consistently in this process have been about learning disability and mental capacity. There has been a conflict for me, even with this amendment, but I am confident that the amendment tabled by my hon. Friend the Member for Penistone and Stocksbridge comes from a very good place. We will come to this next week but, like my hon. Friend, I have consistently listened to Mencap's evidence, which also talked about reviewing the Bill at an earlier stage than is currently envisaged. That is why I have tabled amendments 493, 494 and 495 for next week.

My view is that if the Bill becomes law, the system will work well if the regulations are implemented correctly. I will support the amendment tabled by my hon. Friend the Member for Penistone and Stocksbridge; I thank her for bringing it forward. I know that my hon. Friend the Member for Spen Valley has listened hard, and I am grateful. I think there will be a degree of unanimity this evening.

Danny Kruger: I pay tribute to the hon. Member for Penistone and Stocksbridge for the amendments that she tabled and to the work that she has been doing on our Committee. I regret her victory over my friend, the former MP for Penistone and Stocksbridge, but the hon. Lady is bringing a lot to Parliament and to this Committee.

I am happy to follow the hon. Member for Bexleyheath and Crayford in supporting the amendments. I do not know whether the hon. Lady is in a position to respond with a further speech or by intervening, but I have some

concerns about their operation. I recognise that the role of the independent advocate exists in our system already, very usefully and importantly: I see its value and appropriateness for an assisted dying regime. But if the amendments are accepted, we will be introducing the role of the independent advocate with the sombre recognition that it is necessary, in consequence of a Bill that will allow doctors to discuss ending the patient's life as an option with anybody, no matter how well-equipped or ill-equipped that person may be to handle such a conversation on their own, and no matter how old they are—they could even be 18 years old. I support the amendments, but I do so in recognition of the very significant dangers that I think the Bill represents to all potential applicants.

I want to ask the hon. Member for Penistone and Stocksbridge, or perhaps the Minister or the Bill's promoter, whether they feel that the amendments go to the heart of the concerns raised by the hon. Member for Bexleyheath and Crayford. I am pleased to hear that he is satisfied and will support the amendments, although I echo some of the suggestions of concern that he just made.

New clause 25 makes it clear that the advocate is there to provide support if the person

"is seeking to understand options around end of life care, including the possibility of requesting assistance to end their own life".

Amendment 517 addresses the need for a code of practice when a qualifying person is requesting assistance to end their own life.

My question is whether the new clause and the amendment fully cater for a situation in which that individual is not requesting assistance to end their own life—when they are not seeking to explore that particular option. Given that we have retained the right of medical professionals to raise the possibility of assisted dying unprompted with patients, I am concerned about whether, as I think the hon. Member for Bexleyheath and Crayford implied, the medical professional initiates the conversation, or the advocate themselves is supportive of assisted dying and they deliberately or inadvertently have the effect of encouraging the patient to consider that option.

As I think the hon. Member for Penistone and Stocksbridge said in her intervention on the hon. Member for Bexleyheath and Crayford, new clause 25 creates the role of independent advocate to provide support to a patient, to help them to effectively understand and engage with all the provisions in the Bill. It does not specify that the advocate should be obliged, equipped or experienced in supporting the patient to engage with other options.

Dr Tidball: First, it is necessary that a patient should be able to engage with all the provisions in the Bill. The reason I did not support the previous amendments from my hon. Friend the Member for Bexleyheath and Crayford was that they would only have provided advocacy at too late a stage and would not effectively support a patient at that point we talked about in clause 4, which is around the moment of seeking assistance. I hope that answers the question.

Danny Kruger: I am grateful to the hon. Lady. That is very helpful. That is my concern: we need to ensure all necessary support for the patient at the earliest stage possible.

Dr Tidball: I should add that new clause 25(2)(e), on training, is central and will also assist in that respect. If the Chair will permit, that is why I talked about new clause 27, which builds in a strong structure that can reflect on how the provisions operate in practice.

The Chair: Order. The Member will have an opportunity to speak at the end of the debate. I call Danny Kruger.

Danny Kruger: I thank the hon. Lady. I worry a little about the magic powers of the training fairy, whom we frequently invoke to resolve all the anxieties. We are putting the resolution of difficult tensions on to future professionals and imagining that through training we can resolve all the difficult challenges. However, given the absolute and obvious value of an independent advocate for the people who need that role in the process and given that the hon. Member for Penistone and Stocksbridge has asserted that it is important for the role to be fulfilled at the earliest stage possible, which I entirely agree with, I am happy to support the amendments.

7.45 pm

Stephen Kinnock: Amendment 517 relates to new clause 25, which I will come to next. The amendment would make provision for the Secretary of State to issue a code of practice regarding arrangements for a qualifying person to receive the support of an independent advocate, as set out under new clause 25. The new clause would require the Secretary of State to make regulations about the appointment of independent advocates.

The role of the independent advocate would be to provide support and advocacy to a qualifying person seeking to understand options around end-of-life care, including the possibility of requesting access to assisted dying. A qualifying person is defined in the new clause as someone who has a learning disability, a mental disorder as defined under the Mental Health Act 1983, or autism; or who might experience substantial difficulty in understanding the processes or communicating their views, wishes or feelings; or who meets criteria specified by the Secretary of State in regulations.

Although the new clause would require the Secretary of State to make regulations about the appointment of independent advocates, there is discretion as to what those regulations should include. The new clause sets out a non-exhaustive list of the things that the regulations may provide. The effect of this is that the new clause leaves open who would be obliged to ensure that an independent advocate is present and the precise nature of the obligations around their appointment. It is also unclear how a person would be determined to be a qualifying person, as the definition is quite broad and encompasses a wide range of people with varying support and advocacy needs.

Finally, although the new clause would enable provisions to be made about payments of independent advocates, it is not clear who would make these payments or how they would be funded.

I hope those observations were helpful to the Committee.

Kim Leadbeater: My hon. Friend the hon. Member for Penistone and Stocksbridge has made a powerful and passionate case for the provision of independent advocates, and, as always, has done an outstanding job

[Kim Leadbeater]

of advocating for people with disabilities, including learning disabilities, mental disorders and autism, as she has done throughout this entire process.

It is essential that anybody considering the choice at the end of life made possible by this Bill should fully understand the nature and consequences of any decision they may make. These amendments have made me reflect on comments—I think made by the hon. Member for East Wiltshire a few weeks ago—about the purpose of the Bill. He proposed that the Bill is either about choice and autonomy or it is about safeguards. Actually, this group presents very clear evidence that it is and must be about both, and I hope he can support the amendments.

I take on board the Minister's comments. I heard an element of caution from him, and I am happy to work with the Government and my hon. Friend the Member for Penistone and Stocksbridge if there are any further requirements prior to Report stage, but I am very happy to support the amendment and the new clause.

Dr Tidball: I am grateful for the support of my hon. Friends the Members for Spen Valley and for Bexleyheath and Crayford. It sounds that I may also have the support of the hon. Member for East Wiltshire, which also makes me very happy at this stage of the evening!

I tabled these amendments because I passionately believe in inclusive healthcare for disabled people, removing barriers to such healthcare where possible, and ensuring that disabled people have a strong voice in advocating for themselves and the healthcare they need or desire. I have tried to write the amendment and the new clause to ensure that access to an independent advocate operates across the functions of the Bill. I have been keen to ensure that this provision acts in conjunction with new clause 27, which I will speak about at a later stage. I hope, as I said in an earlier response to the hon. Member for East Wiltshire, that that will provide a solid and robust opportunity to monitor the impact on disabled people of the Bill, if it does pass through Parliament, through its implementation and in practice. Taken together, the measures will create a solid foundation to enable disabled people to have a voice and will provide a strong structure for accountability in the Bill.

I acknowledge the Minister's comments, and will work with him and my hon. Friend the Member for Spen Valley to ensure that it is watertight.

Amendment 517 agreed to.

Amendment made: 534, in clause 30, page 18, line 30, at end insert—

"(da) the forms of proof of identity that are acceptable for the purposes of section 6."—*(Jack Abbott.)*

Amendment made: 523, in clause 30, page 18, line 31, leave out paragraph (e) and insert—

"(1A) The Secretary of State may issue one or more codes of codes of practice in connection with any matters relating to the operation of this Act not required under subsection (1) as the Secretary of State considers appropriate."—*(Danny Kruger.)*

This amendment, which works together with Amendment 447, would clarify that the Secretary of State is not required to issue a code of practice under subsection (1)(e) but instead has the discretionary power to issue further codes of practice as the Secretary of State considers appropriate.

Amendment made: 417, in clause 30, page 18, line 32, at end insert—

"(1A) The Secretary of State must, within six months of the passing of this Act, issue one or more codes of practice in connection with the arrangements for ensuring effective communication in connection with the provision of assistance to persons in accordance with this Act, including the use of interpreters."—*(Jack Abbott.)*

This amendment is linked to Amendment 416.

Amendments made: 216, in clause 30, page 18, line 37, leave out subsection (4).

See the statement for Amendment 188.

Amendment 217, in clause 30, page 18, line 38, leave out "that procedure" and insert "section 39".—*(Kim Leadbeater.)*

See the statement for Amendment 188.

Danny Kruger: On a point of order, Mrs Harris. Before I move the next amendment, I wish to correct the record. I do not know if this is the moment to do so, but I wish to correct a mistake I made earlier today.

The Chair: Yes, go on then.

Danny Kruger: I am grateful, Mrs Harris. Earlier, I cited evidence about an exodus of care workers from the Australian care system. Members challenged me on that—fairly. I have been looking since, and I could not find the evidence that was in my mind. I think I was confusing it with evidence about the number of palliative care professionals who said that they would not want to work in the sector if assisted dying were performed by their organisations. The only evidence I have got on Australia was from Robert Clark, the Attorney General, who, rather than referring to statistics, gave his own evidence on how many professionals are leaving the Victorian hospital system in consequence of the introduction of voluntary assisted dying. I thought I had statistical evidence to show an exodus, but I did not. I am correcting the record and I apologise to the Committee.

The Chair: I thank the hon. Member.

Danny Kruger: I beg to move amendment 524, in clause 30, page 18, line 40, leave out from "have regard to" and insert "comply with".

This amendment would require individuals to comply with the Codes of Practice issued by the Secretary of State.

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

Danny Kruger: The amendment would specify that individuals should comply with the codes of practice issued by the Secretary of State. I am glad that the hon. Member for Spen Valley agreed to accept an earlier amendment requiring the Secretary of State to issue codes of practice. That was a helpful step, but it is not quite sufficient, because it does not address the critical weakness in the Bill. Time and again, we have been told that amendments tabled are not suitable for the face of the Bill and that we should rely on codes of practice and

guidance that will be issued subsequently. Now we are at this point, though, and it is clear that under clause 30(6) the code of practice is something that those

"performing any function under this Act must",

simply, "have regard to".

We have been told repeatedly by the Minister that the Government's preference is to leave things until later and not to address issues on the face of the Bill, because additional words, phrases and amendments would increase risk and be counterproductive. That is an argument that we have heard from the Government Front Bench repeatedly. Other Members have dismissed as embroidery suggested amendments to strengthen safeguards; it has been suggested that the more we write, the less safe the Bill will be. I do not think those arguments will survive the other place, if the Bill arrives there. There is a vast difference between something in the Bill that must be "complied with" because it is in legislation, and something that those providing assistance under the Bill must only "have regard to". It is perplexing that the Bill does not clearly specify that practitioners should "follow" or "act in accordance with" the guidance. These words matter.

The Office of the Parliamentary Counsel explores the choice of these different phrases in its guidance on common legislative problems. That guidance was produced by the drafter of this Bill, the former First Parliamentary Counsel, Elizabeth Gardiner. It is quite a deliberate policy choice to leave compliance with these codes of practice to the discretion of the individuals rather than to require it. The guide to making the legislation—the Cabinet Office manual, which the drafter would have been very familiar with—states:

"A 'code of practice' is an authoritative statement of practice to be followed in some field. It typically differs from legislation in that it offers guidance rather than imposing requirements: its prescriptions are not hard and fast rules but guidelines which may allow considerable latitude in their practical application and may be departed from in appropriate circumstances. The provisions of a code are not directly enforceable by legal proceedings…

Codes of practice are not to be used to define specific legal obligations. Where specific legal obligations are to be imposed, breach of which leads directly to civil or criminal liability, their content should be spelled out in primary or secondary legislation. A code of practice is not appropriate for this purpose, either to delineate the main obligation or to provide for exceptions or defences."

I do not think it appropriate that so much is being left to ministerial discretion. I find this perplexing. Not to make a party-political point, but we know how much Labour MPs distrust Conservatives, and yet they are seemingly willing—as indeed, Conservative colleagues in support of this are—

The Chair: Order. Can we keep to the point?

Danny Kruger: The point I am making is that we are suggesting that some future Secretary of State, in a different Government of which we know nothing, might decide to issue codes of practice that will determine how this process is delivered, but I will leave that point.

We must address the weak status of these codes of practice. I regret that they are being left in this weak form. At a minimum level, we should require that they are properly complied with. This cannot be remedied after the Bill has passed. No matter how strong the language in the codes of practice, that language cannot override or change the nature of a statutory duty. Any enhanced duty has to come from a source external to the document being considered itself—namely, the statute. I ask the hon. Member for Spen Valley, why not insist that practitioners comply with the relevant provisions of the code?

Stephen Kinnock: I will speak on amendment 524, in the name of the hon. Member for East Wiltshire. As the Bill stands, a person is required to "have regard to" any codes of practice issued by the Secretary of State when performing a function under the Bill. Amendment 524 would mean that individuals are instead required to "comply with" the codes of practice issued. That could limit someone to doing only what is specified in the code, rather than allowing them to exercise their professional discretion to perform the function in the most appropriate way, having given regard to the code. It is also unclear from the amendment who would monitor or enforce compliance with the codes. Codes of practice are normally detailed practical guidance on how to comply with legal obligations, and are generally not legally binding.

I hope those observations are helpful to the Committee.

Kim Leadbeater: I understand the sentiment behind the amendment, but as the Minister said, codes of practice serve a particular purpose. Everyone has to comply with and abide by the law, but codes of practice are there to assist in the exercise of a person's professional judgment. I worry about losing the ability for professionally trained and regulated people to use their professional discretion and have the flexibility they need to do their jobs well, if we accepted this amendment.

I think the hon. Member for East Wiltshire answered his own question in his description of what a code of practice does. Although the amendment comes from a good place, I cannot support it. We need to have flexibility, and trust in our professionals to do their job.

8 pm

Question put, That the amendment be made.

The Committee divided: Ayes 7, Noes 13.

Division No. 70]

AYES

Abbott, Jack	Olney, Sarah
Francis, Daniel	Shah, Naz
Joseph, Sojan	
Kruger, Danny	Woodcock, Sean

NOES

Atkinson, Lewis	Malthouse, rh Kit
Charalambous, Bambos	Paul, Rebecca
Gordon, Tom	Richards, Jake
Green, Sarah	Sackman, Sarah
Hopkins, Rachel	Shastri-Hurst, Dr Neil
Kinnock, Stephen	Tidball, Dr Marie
Leadbeater, Kim	

Question accordingly negatived.

Clause 30, as amended, ordered to stand part of the Bill.

Clause 31

Guidance from Chief Medical Officers

Daniel Francis: I beg to move amendment 395, in clause 31, page 19, line 8, at end insert—

"(2A) The persons consulted under subsection (2) must include persons with learning disabilities.".

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

Amendment 396, in clause 31, page 19, line 14, at end insert—

"(ba) persons with learning disabilities;".

Clause stand part.

Daniel Francis: These amendments refer to the oral evidence we received from Mencap. They would add provisions to ensure those consulted in the preparation of the chief medical officer's guidance include persons with learning disabilities. I commend the amendments to the Committee.

Stephen Kinnock: Clause 31(2) provides that, before preparing guidance under the clause, the relevant CMO must consult such persons as they consider appropriate. Amendment 395 would add a duty for the CMO to consult persons with learning disabilities before preparing such guidance. That may call into question why other specific groups are not expressly listed.

Amendment 396 would include persons with learning disabilities as an additional category of people to which the CMOs must have regard in relation to preparing practical and accessible information, advice and guidance under clause 31. The effect would be to include persons with learning disabilities as a specific category of people in addition to the listed categories. This could imply that those with learning disabilities would not already be included in one of the categories already listed, namely

"persons requesting or considering requesting assistance to end their own lives…next of kin and families of such persons"

and "the general public."

Clause 31 sets out a duty on the chief medical officers for England and Wales to publish public-facing guidance relating to the operation of the legislation. It has rightly been a matter for the Committee to determine amendments to the clause, and the Government will respect the will of Parliament. As Members will know, the Government have been working with the Bill's promoter, my hon. Friend the Member for Spen Valley, on amendments to ensure that, if passed, the legislation will be legally robust and workable.

On this clause, we intend to support the development of further such technical amendments on Report. Where amendments are required to clarify the obligations in relation to the preparation of guidance, we will work with the promoter to ensure that MPs receive good notice to give them adequate time for consideration. I hope those observations were helpful for the Committee.

Kim Leadbeater: I briefly show my support for these amendments that have been tabled by my hon. Friend the Member for Bexleyheath and Crayford.

Amendment 395 agreed to.

Amendment made: 396, in clause 31, page 19, line 14, at end insert—

"(ba) persons with learning disabilities;"—*(Daniel Francis.)*

Clause 31, as amended, ordered to stand part of the Bill.

Ordered, That further consideration be now adjourned. —*(Bambos Charalambous.)*

8.6 pm

Adjourned till Tuesday 25 March at twenty-five minutes past Nine o'clock.

Written evidence reported to the House

TIAB 431 Katharine Lovell, band 5 staff nurse

TIAB 432 Rebecca Wilcox

TIAB 433 An individual who wishes to remain anonymous

TIAB 434 Dr Vicki Ibbett, MRCPsych, NHS specialty doctor in psychiatry