

# PARLIAMENTARY DEBATES

HOUSE OF COMMONS  
OFFICIAL REPORT  
GENERAL COMMITTEES

## Public Bill Committee

### TERMINALLY ILL ADULTS (END OF LIFE) BILL

*Twenty-ninth Sitting*

*Tuesday 25 March 2025*

*(Afternoon)*

---

#### CONTENTS

CLAUSE 32 disagreed to.  
CLAUSES 33 TO 43 agreed to, some with amendments.  
New clauses considered.  
SCHEDULES 1 TO 6 disagreed to.  
New schedules considered.  
Bill, as amended, to be reported.  
Written evidence reported to the House.

---

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

**not later than**

**Saturday 29 March 2025**

© Parliamentary Copyright House of Commons 2025

*This publication may be reproduced under the terms of the Open Parliament licence, which is published at [www.parliament.uk/site-information/copyright/](http://www.parliament.uk/site-information/copyright/).*

**The Committee consisted of the following Members:**

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

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

## Public Bill Committee

Tuesday 25 March 2025

(Afternoon)

[CAROLYN HARRIS *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? Tea and coffee are not permitted in the Committee Room.

We will now continue line-by-line scrutiny of the Bill. I remind Members that interventions should be short and should raise points of clarification or questions; they should not be speeches. Members who wish to give a speech should continue to bob at the appropriate points throughout the debate in which they wish to take part, until they are called. When Members say “you”, they are referring to the Chair; they should not use “you” to refer to one another.

#### Clause 32

SECRETARY OF STATE’S POWERS TO ENSURE ASSISTANCE IS AVAILABLE

*Amendment proposed (this day):* 525, in clause 32, page 19, line 26, leave out subsection (2).—(*Danny Kruger.*)

*Question again proposed,* That the amendment be made.

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

Amendment 537, in clause 32, page 19, line 27, after “assistance” insert

“by a registered charity but not”.

*This amendment would limit the provision of an assisted death to charitable providers and not permit provision as part of the National Health Service.*

Amendment 528, in clause 32, page 19, line 27, at end insert—

“(2A) Regulations under subsection (1) cannot authorise a body other than a public authority from providing such assistance even if that body is to be contracted by a public authority to do so.”

Amendment 529, in clause 32, page 19, line 28, leave out subsection (3).

Amendment 530, in clause 32, page 19, line 31, at end insert—

“(5) The Secretary of State may not lay a draft statutory instrument before either House of Parliament that makes provision containing (whether alone or with other provision) regulations under subsection (1) unless they also lay before both Houses an impact assessment on such regulations.

(6) The impact assessment under subsection (5) must include an assessment of the impact of such regulations on the workforce of health professionals and on the National Health Service.”

Clause stand part.

Amendment 545, in clause 39, page 23, line 6, leave out subsections (3) to (5) and insert—

“(3) The Secretary of State may not make a statutory instrument containing (whether alone or with other provision) regulations under section 5(3A), 8(6A), 30(3), (Voluntary assisted dying services: England) or (Voluntary assisted dying services: Wales) unless a draft of the instrument has been laid before, and approved by a resolution of, each House of Parliament.

(4) Any other statutory instrument made by the Secretary of State containing regulations under this Act is subject to annulment in pursuance of a resolution of either House of Parliament.

(5) The Welsh Ministers may not make a statutory instrument containing regulations under section (Voluntary assisted dying services: Wales) unless a draft of the instrument has been laid before, and approved by a resolution of, Senedd Cymru.”

*This amendment brings together the various provisions about the procedure for regulations. It also makes regulations under clauses 5 and 8 about training, qualifications and experience, and regulations under NC36 and NC37, subject to the draft affirmative procedure.*

New clause 36—*Voluntary assisted dying services: England*—

“(1) The Secretary of State must by regulations make provision securing that arrangements are made for the provision of voluntary assisted dying services in England.

(2) In this section “commissioned VAD services” means services provided by virtue of regulations under subsection (1).

(3) The Secretary of State may by regulations make other provision about voluntary assisted dying services in England (whether or not the services are commissioned VAD services).

(4) Regulations under this section may for example provide that specified references in the National Health Service Act 2006 to the health service continued under section 1(1) of that Act include references to commissioned VAD services.

(5) Regulations under this section must provide that section 1(4) of that Act (services to be provided free of charge except where charging expressly provided for) applies in relation to commissioned VAD services.

(6) Regulations under this section may make any provision that could be made by an Act of Parliament; but they may not amend this Act.

(7) In this section “voluntary assisted dying services” means—

(a) services for or in connection with the provision of assistance to a person to end their own life in accordance with this Act, and

(b) any other services provided by health professionals for the purposes of any of sections 4 to 22 except section (Determination by panel of eligibility for assistance).”

*This new clause imposes a duty on the Secretary of State to make regulations securing that arrangements are made for the provision of voluntary assisted dying services in England. It also confers a power to make other provision about voluntary assisted dying services in England.*

Amendment (a) to new clause 36, after subsection (1) insert—

“(1A) Regulations under subsection (1) cannot authorise the National Health Service in England to provide voluntary assisted dying services.”

Amendment (c) to new clause 36, after subsection (1) insert—

“(1A) Regulations under subsection (1) cannot authorise a body other than a public authority to provide voluntary assisted dying services if that body is to be contracted by a public authority to do so.”

Amendment (b) to new clause 36, leave out subsections (4) and (5) and insert—

“(4) Regulations under subsection (1) may not amend, modify or repeal section 1 of the National Health Service Act 2006.”

Amendment (d) to new clause 36, leave out subsection (6).

Amendment (e) to new clause 36, after subsection (6) insert—

“(6A) The Secretary of State may not lay a draft statutory instrument before either House of Parliament that makes provision containing (whether alone or with other provision) regulations under subsection (1) unless they also lay before both Houses an impact assessment on such regulations.

(6B) The impact assessment under subsection (6A) must include an assessment of the impact of such regulations on the workforce of health professionals and on the National Health Service.”

New clause 37—*Voluntary assisted dying services: Wales*—

“(1) The Welsh Ministers may by regulations make provision about voluntary assisted dying services in Wales, including provision securing that arrangements are made for the provision of such services.

(2) Regulations under subsection (1) may make any provision that—

(a) could be made by an Act of Senedd Cymru, and

(b) would be within the legislative competence of the Senedd if it were contained in such an Act.

(3) The Secretary of State may by regulations make provision about voluntary assisted dying services in Wales.

(4) Regulations under subsection (3) may make any provision that—

(a) could be made by an Act of Parliament, and

(b) would not be within the legislative competence of the Senedd if it were contained in an Act of the Senedd.

(5) Regulations under this section may not amend this Act.

(6) In this section “voluntary assisted dying services” has the meaning given by section (Voluntary assisted dying services: England).”

*This new clause confers a power on the Welsh Ministers to make provision about voluntary assisted dying services in Wales, including provision securing that arrangements are made for the provision of such services. It also confers a power on the Secretary of State to make provision about such services, where the provision would be outside the legislative competence of Senedd Cymru.*

**Naz Shah (Bradford West) (Lab):** It is a pleasure to serve under your chairmanship, Mrs Harris, for what might be the last time on this Bill Committee. When we adjourned this morning, I was speaking to new clauses 36 and 37. To bring us up to speed, I will repeat my last paragraph.

If the interpretation that I suggested this morning is correct, surely we could have tighter wording. For example, the new clause could say that if the Secretary of State decides to allow private firms to provide assisted dying to paying customers, the Secretary of State must make regulations to govern that. I would welcome clarification from my hon. Friend the Member for Spen Valley on whether she would be minded to accept such an amendment, given that she accepted a change from “may” to “must” in previous amendments.

Finally, we come to what I think is the most important part of new clause 36: the powers in subsection (1) to commission assisted dying services. How the Secretary of State uses those powers will be crucial to the transparency of the system and to the impact of assisted dying on the NHS.

We do not know whether the Health Secretary will contract private firms to provide services to the NHS or whether all assisted dying will be provided under the NHS. We do know, however, that many parts of the medical profession are strongly alarmed by the idea that the NHS would provide assisted dying. For example, the Royal College of General Practitioners said in its written evidence TIAB 108 that it

“does not believe that, if assisted dying is legalised, the process should be integrated into existing care pathways as part of the standard care and treatment they provide i.e. assisted dying should not be deemed core GP work...As such, we consider that if assisted dying is legalised the Bill should make provision to establish a separate Assisted Dying service. This may help to ensure that assisted dying was not a core part of GP work and that any doctor who did not want to be involved would not be forced to do so.”

There is a problem here. Giving the Health Secretary the power to commission private firms to work as contractors to provide assisted dying would perhaps solve that problem, with skilled healthcare professionals working in the private sector. In an interview with *The Guardian* on 10 January, the Health Secretary said:

“Where there is spare capacity in the independent sector we will use it. We have agreed that we will work with them, and they will work with us to cut NHS waiting times...At the same time the independent sector has to pull its weight. It’s got to be genuinely additional capacity. I’m entirely pragmatic about this”.

I agree entirely with my right hon. Friend that where there is genuine capacity in the private sector to help the NHS to complete its tasks, we should of course use that capacity. However, it is not only private sector healthcare firms that are likely to bid for any future assisted dying contract. There are other firms with a good chance of winning those contracts that we should be very concerned about.

The Minister for Care has made it clear that the Government are considering using private firms for assisted dying. He gave an important interview on assisted dying to *PoliticsHome*, which was published on 11 March. He said that my hon. Friend the Member for Spen Valley

“has said that she wants this service to be an integral part of the NHS, meaning free at the point of use. Certainly the advice that we as ministers have given her is we’ve clearly understood that that is her wish, and that is a wish that can be delivered and carried out. Now, free at point of use doesn’t preclude the use of independent contractors to deliver the service. So, yeah, we’re comfortable with that.”

Unfortunately, we have seen major failings in the way private firms handle important contracts given to them by the Government. Those failings have happened under all three major parties in England and Wales. I want to quote from an excellent book by Sam Freedman, “Failed State”, which is not about some foreign country but about our own. I should say that Sam Freedman was a special adviser to Michael Gove under the Conservative Government, so he is not someone on the far left.

Chapter 3 of the book, which concerns outsourcing, is entitled “Contract Killing”. It says that outsourcing contracts can work well if three conditions are met. First, there need to be many firms or public organisations competing to offer a service. Secondly, the regulator needs to be able to measure clearly whether the firms have delivered the service to a good standard. Finally,

[Naz Shah]

“government needs to be able to hand over most of the risk of failure—if the taxpayer is still on the hook for picking the costs if things go wrong then the premium paid to private firms is not justified.”

There are fields in which Government contracts do meet those criteria and outsourcing works very well—cleaning services, for example. There are some diagnostic or therapeutic services in the NHS for which private firms can make a genuinely competitive offer. A lot of the time, however, that does not happen:

“For more complex services, though, often none of these criteria apply. Take a specialist activity like running immigration processing. There is no existing market. That means there are few plausible bidders outside of a handful of huge multinational outsourcing firms.”

It means, as Freedman notes, that the UK’s outsourcing market is dominated by the big four: Serco, Capita, Atos and G4S. There must be a very good chance that these companies will end up bidding for assisted dying services. Freedman gives immigration processing as an example of a complex service in which there are not going to be a lot of companies making good, competitive bids. Assisted dying is even more complex than immigration processing, and it is even more important to get it right.

To bid for assisted dying services, companies will need experience in securing complex Government contracts. They will need very good legal advice. They will need to hire doctors and other specialist staff. They will need the facilities to transport and store lethal drugs. We are almost certainly going to see the same old big four outsourcing companies bidding for these contracts. That would be a major problem, because the big four have a terrible record. I apologise for not being able to give a complete list of the scandals in which these four firms have been involved while running Government contracts—after all, time is limited—but it is worth mentioning a few.

In 2013, both Serco and G4S were found to have spent years keeping inaccurate records on how they tagged and monitored dangerous criminals. As a result, they had overcharged the Government by tens of millions of pounds. Serco was eventually fined £23 million for fraud and false accounting; G4S was fined £44 million for the same scandal, but that only happened in 2020, seven years after its fraud was first revealed. These two companies committed fraud against the taxpayer worth tens of millions of pounds.

**The Chair:** Order. Please could I ask the hon. Member to stick to the point?

**Naz Shah:** I will get back to the point, Mrs Harris.

Serco and G4S carried on getting huge public contracts because the Government found it too hard to replace them. Assisted dying would also be a specialised service.

**Kim Leadbeater** (Spennings Valley) (Lab): My hon. Friend has mentioned a couple of companies. I have to say that I do not know very much about those companies. Are they healthcare providers? Do they deliver healthcare?

**Naz Shah:** Some of them do, or they deliver parts of healthcare. Any company can bid or design a service to recruit doctors, as I said earlier. That is the reason I

mention these companies. Big companies already do provide some services to our NHS, albeit that they may be in different areas at the moment.

**The Chair:** Order. Can we stick to the point, please?

**Naz Shah:** I am happy to, Mrs Harris.

We should be determined not to see big outsourcing companies bidding for assisted dying contracts and then potentially misusing them the way in which they have misused other public services. That is not because I am opposed to firms operating in a free market or making money when they do their job well; it is because the way we run outsourced Government contracts in this country often has nothing to do with the free market and nothing to do with companies working well.

Finally, we need to ask hard questions about how the contracts for assisted dying would be structured. Would companies be paid a fee for each stage of the assisted dying process that they have provided: one fee for providing the first assessment by a doctor, another for a second assessment and so on, up until the final fee for helping the patient take the lethal drugs? As I said this morning, we do not know what the proposal for the structure is. That is why it is important that we explore and understand the risks of every structure.

There are Government services that we can safely outsource. Assessing whether people are fit to end their life is not one of them, and neither is helping people to take lethal drugs. These clauses will enable future Governments to open up lucrative contracts for assisted dying that will almost certainly be won by companies that have often been incompetent and have potentially been dishonest. I strongly oppose the new clauses.

**Danny Kruger** (East Wiltshire) (Con): I share all the hon. Lady’s concerns. In relation to the intervention made by the hon. Member for Spennings Valley, is she aware that G4S has a health services division in the UK that directly employs doctors and other healthcare professionals?

**The Chair:** Order. Mr Kruger, we have already had that issue. We need to stick to the amendments.

**Danny Kruger:** I take your ruling, Mrs Harris, but the amendment is explicitly about this.

**Naz Shah:** When it comes to NHS providers, or any service providers, and contracting or outsourcing, we have legislation in this place for whistleblowing. I raised the subject with the Health Secretary in relation to my local trust only today. With the best will in the world, mistakes happen. We legislated to protect whistleblowers, and that ties in directly to these risks. We must do everything we can to mitigate such risks in the Bill.

**The Minister for Care** (Stephen Kinnock): It is a great pleasure to serve under your chairship this afternoon, Mrs Harris. The Government remain committed to ensuring the legal robustness and workability of all legislation. For that reason, we have worked with my hon. Friend the Member for Spennings Valley on some amendments to the Bill. Where changes have been

mutually agreed by my hon. Friend and the Government, I will offer a technical, factual explanation and a rationale for the amendments.

Amendment 525 would remove the Secretary of State's explicit power to make regulations enabling the provision of assistance as part of the health service in England and Wales. It might therefore prevent such assistance from being provided by the NHS. The Secretary of State would still have the power to make arrangements for the provision of assistance or to delegate the making of arrangements. However, it is doubtful that those arrangements could be made through the NHS; rather, the Secretary of State could, for example, make arrangements for another body to provide assistance.

The effect of amendment 537, as drafted, is potentially ambiguous. However, the Government's assessment is that it could be interpreted as allowing regulations to enable the provision of assisted dying by a registered charity, while not allowing provision as part of the health service. That could put into doubt whether assisted dying could be provided as part of the NHS in England and Wales.

Amendment 528 would prevent any body other than a public authority from being authorised by regulations to provide assistance as set out in the Bill, regardless of whether that body is contracted to do so by a public authority. That would limit the scope of the Secretary of State's powers to ensure that assistance is available in the absence of a definition. The meaning of "public authority" might be unclear.

Amendment 529 would remove the power to amend, revoke or repeal legislation via regulations made under clause 32(1) concerning arrangements for assistance, where passed or made before the end of the Session in which the Bill is passed. That could lead to gaps in the Secretary of State's regulation-making powers and in other legislation. It could also have an impact on the workability of arrangements for assistance and, ultimately, the Bill.

Amendment 530 would add two requirements when making regulations under clause 32, which sets out the Secretary of State's powers to ensure that assistance is available. The first is that the Secretary of State may not lay regulations before either House under subsection (1) unless an impact assessment of those regulations is also laid before both Houses. The second is that the impact assessment must include an assessment of the impact of the regulations both on the health professional workforce and on the NHS itself. Impact assessments are routinely prepared to accompany secondary legislation. However, the amendment would impose a statutory requirement on the Secretary of State to prepare an impact assessment, which would need to be laid before both Houses. It would therefore create a legal requirement that is not the standard for secondary legislation.

2.15 pm

Clause 32 gives the Secretary of State the power to make necessary provisions so that assistance can be provided in accordance with the Bill. Amendment 545 clarifies that various regulations made under the Bill are subject to the affirmative procedure. That includes regulations about training, qualifications and experience, about when any code of practice comes into force, and about the provision of a voluntary assisted dying service

in England and Wales. Although regulations about the commencement of any codes of practice are already subject to the affirmative procedure, this amendment will mean that regulations relating to the required training, qualifications and experience, and the provision of a voluntary assisted dying service in England and Wales, will be subject to increased parliamentary scrutiny, compared with the Bill as drafted. The amendment also clarifies that any other regulations made by the Secretary of State will be subject to the negative procedure.

In addition, the amendment provides that Welsh Ministers may not make regulations in relation to the voluntary assisted dying service unless a draft of the regulations has been laid before and approved by the Senedd. That means that regulations about the voluntary assisted dying service in Wales will be subject to increased scrutiny and debate in the Senedd.

New clause 36 imposes a duty on the Secretary of State to make regulations to ensure that arrangements are made for voluntary assisted dying services to be provided in England. It also imposes a power on the Secretary of State to make other provision about matters related to voluntary assisted dying services in England. The regulations made by the Secretary of State can provide that references to the health service in the National Health Service Act 2006 include references to a voluntary assisted dying service in England. That ensures that voluntary assisted dying services can be provided via the NHS. The new clause further ensures that voluntary assisted dying services provided as part of the health service must be free of charge unless charging is expressly provided for.

**Danny Kruger:** First, on the proposed amendment to the NHS Act, will the Minister confirm that the implication is that it is not currently possible to deliver assisted dying services under the Act? Secondly, to help me understand new clause 36, is it proposed that the Government will amend the NHS Act through regulations, a statutory instrument, or will the courts read the new clause as inferring that assisted dying is compatible with the NHS Act? Is there an intention to change the wording of the NHS Act, or is it just that we should now read "healthcare" as including assisted dying? I would be very grateful if the Minister could explain, because it is not clear to me from the phrasing.

**Stephen Kinnock:** New clause 36 creates the basis for the provision of assisted dying services, in compliance with all the legislation that defines how the national health service works. If the new clause is agreed by the Committee, and ultimately by Parliament, further amendments and changes will not be required. It will be the basis for the provision of the assisted dying service, within the framework of all the legislation that defines how the NHS works.

**Danny Kruger:** New clause 36 specifies that the NHS Act will require amendment. Is the Minister saying that that is not in fact the case?

**Stephen Kinnock:** New clause 36 specifies that the Secretary of State will, by regulation, set out the operating framework for the delivery of the assisted dying service. That will be the change to the legislation that is required.

[Stephen Kinnock]

I apologise to the hon. Gentleman if I am missing something. I do not know whether we are talking at cross purposes here. What I am saying is that new clause 36 provides the basis for the delivery of the service. I am sorry if I am missing his point, but that is my understanding.

**Kim Leadbeater:** The Minister is absolutely right. The point is that new clause 36 provides that provision for assisted dying services can be made through the NHS. It gives flexibility: if the NHS Act needed to be amended, it could be, but that is certainly not the intention at this stage. The Act has been amended on numerous occasions, not least by the Health and Social Care Act 2012.

**Stephen Kinnock:** I thank my hon. Friend for that clarification. It is very helpful, because I perhaps did not quite understand what the hon. Member for East Wiltshire said. My hon. Friend sets out very clearly the optionality represented in new clause 36.

The new clause further ensures that voluntary assisted dying services provided as part of the health service must be free of charge, unless charging is expressly provided for. Subsection (6) confirms that regulations made under this new clause can make provisions with the same effect as an Act of Parliament, including amending other primary legislation. However, they cannot amend the provisions in this Bill. The amendment also defines voluntary assisted dying services.

Amendment (a) to new clause 36 would prohibit regulations being made that authorise the provision of voluntary assisted dying services by the NHS in England. The Secretary of State would still have a duty to ensure that arrangements are made for the provision of assistance, but not by the NHS. The Secretary of State could, for example, make arrangements for another body to provide assistance, which would mean that the Secretary of State could not ensure that assistance was provided in accordance with the Bill or through the NHS in England. This would apply only to England, not Wales. Welsh Ministers could still make regulations for the provision of voluntary assisted dying services by the NHS in Wales. This could result in a divergence between England and Wales in the provision of assisted dying services.

**Liz Saville Roberts (Dwyfor Meirionnydd) (PC):** The Committee should be aware that the Isle of Man has today passed an assisted dying Act, and we already have divergence between the different jurisdictions of the United Kingdom.

**Stephen Kinnock:** I think we are all moving in a direction where, if this Bill passes, we would like its delivery in England and Wales to be compatible, based on full respect for the devolution settlement and for the legislative consent motions. Divergence in the context of the devolution settlement is what the right hon. Lady is keen to achieve, and I think she is working with my hon. Friend the Member for Spen Valley to achieve that aim.

Amendment (b) to new clause 36 would provide that the Secretary of State must, by regulations, make arrangements for the provision of assisted dying services in England. The amendment would remove the provision

that regulations under new clause 36 may provide that specified references to the health service in the NHS Act include reference to commissioned assisted dying services. Secondly, it removes subsection (5), which states that regulations under new clause 36

“must provide that section 1(4) of”

the NHS Act

“applies in relation to commissioned VAD services”,

which provides that health services must be free of charge unless exceptions apply. Finally, amendment (b) to new clause 36 explicitly provides that regulations made under subsection (1)

“may not amend, modify or repeal section 1 of the National Health Service Act 2006.”

If accepted, the proposed amendment may impact the provision of assisted dying services through the health service in England. The effect would be that section 1 of the NHS Act could not be amended, modified or repealed via regulations under new clause 36(1). The proposed amendment applies only to England, and the restriction does not apply to Welsh Ministers. This could result in a divergence between England and Wales in the provision of assisted dying services, as Welsh Ministers could amend section 1 of the National Health Service (Wales) Act 2006.

Amendment (c) to new clause 36 would limit the scope of the Secretary of State’s power in subsection (1) of new clause 36 to make regulations that secure arrangements for the provision of voluntary assisted dying services in England. Under this amendment, such regulations cannot authorise the provision of assistance by a body other than a public authority, even if that body is contracted by a public authority to do so. That would effectively prevent the NHS from contracting with private providers to provide assistance. The NHS regularly contracts private providers to provide NHS services. It is possible that being unable to do so here may present operational challenges. The amendment applies only to England, and the restriction does not apply to Welsh Ministers. That could result in a divergence between England and Wales in the provision of voluntary assisted dying services.

Amendment (d) to new clause 36 seeks to limit the Secretary of State’s power to amend, revoke or repeal other legislation for the purpose of making provision for assisted dying services.

**Rebecca Paul (Reigate) (Con):** I am sorry to backtrack slightly, but I want to clarify that the Isle of Man is a Crown dependency and not part of the UK.

**Stephen Kinnock:** The hon. Member is absolutely right that it is a different situation from the point of view of devolution. Perhaps my answer was conditioned by the intervention of the right hon. Member for Dwyfor Meirionnydd, so I perhaps jumped to a conclusion.

**Liz Saville Roberts:** On that point, we are also expecting a decision in Holyrood in Scotland, which I think the Committee will agree is part of the United Kingdom. These jurisdictions influence our discussions in this place.

**Stephen Kinnock:** The right hon. Lady makes a valid point, although Scotland has a different legal system from the one that governs England and Wales. That



takes us back to the legal jurisdiction question versus the devolution of health service delivery. How to make those two work compatibly is a key challenge that the Committee is seeking to address.

Amendment (d) to new clause 36 could limit the Secretary of State's ability to make provision for assisted dying services via the health service in England. For example, it could limit who can commission and regulate assisted dying services, as the Secretary of State will not have the power to amend primary legislation. If the amendment were agreed, the Secretary of State would not be able to make, via regulation, the required amendments to relevant legislation for the purpose of enabling the provision of assisted dying services in England. The Committee may wish to note that the amendment would apply only to England, which could lead to a divergence in provision between England and Wales.

Amendment (e) to new clause 36 would add two requirements. First, it would provide that the Secretary of State could not lay regulations concerning the provision of voluntary assisted dying services in England unless an impact assessment of the regulations is also laid before both Houses of Parliament. Secondly, the impact assessment would need to include

“an assessment of the impact of such regulations on the workforce of health professionals and on the National Health Service.”

An impact assessment is routinely prepared to accompany secondary legislation. The amendment would impose a legal requirement on the Secretary of State to prepare an impact assessment that must be laid before both Houses to assess the impact on the workforce of health professionals and on the NHS in England. Practically, this could cause delays in making regulations under the Bill, by requiring a duplicative impact assessment to accompany each set of regulations, including regulations that make minor or consequential amendments. *[Interruption.]*

**The Chair:** Order. The Division bell is ringing. There will be multiple votes, so I suggest that we suspend for 45 minutes.

2.28 pm

*Sitting suspended for Divisions in the House.*

3.16 pm

*On resuming—*

**Stephen Kinnock:** I was cut off in my prime, but I am ready to start again.

New clause 37 will give the Welsh Ministers a power to make regulations about voluntary assisted dying services in Wales, including regulations to secure that arrangements are made for voluntary assisted dying services to be provided in Wales. Such regulations can make any provision that could be made by an Act of Senedd Cymru and that would be within the legislative competence of the Senedd if it were contained in such an Act. The Secretary of State will be able to make regulations about such services where this would be outside the legislative competence of Senedd Cymru.

Subsection (6) confirms that regulations made under the new clause can make provisions with the same effect as an Act of Parliament, including amending other

primary legislation. However, they could not amend the provisions in the Bill. I hope that those observations have been helpful to the Committee.

**Kim Leadbeater:** We have had some excellent and extremely thorough debates covering all aspects of the Bill since the Committee first met. There has been an unprecedented level of scrutiny, and rightly so, given the gravity of the issue. The clause before us is one of the most important that we will consider. Without it, the Bill's objective of offering a compassionate and dignified choice to terminally ill adults could not be met. The injustices of the status quo would remain, with too many people travelling abroad to seek an assisted death or taking matters into their own hands here at home, alone and often before they need to, in order to protect their loved ones from the threat of prosecution. Those people would be left, as they are now, with no protections against coercion or pressure to end their life and, crucially, with no ability to choose the manner and timing of their death so that they can say goodbye and be remembered by their loved ones as they would wish.

Clearly, some hon. Members do not want those people to have that choice. They are fully entitled to that view. However, if Parliament decides otherwise and gives that choice, it is our responsibility to ensure that it can be exercised without adding constraints and impediments that would serve only to make people's last days and weeks more traumatic, not less. That is one reason, although not the only reason, why I am clear that the process must be available as part of the range of services available to patients under the NHS and free at the point of need. It must be for the Secretary of State to make provision for the service in England, and for Ministers in Wales to do the same in Wales if the Senedd agrees. The House of Commons must have the opportunity to scrutinise the regulations under the affirmative procedure.

Despite the challenges that it faces, the NHS is a trusted institution staffed by some of the best qualified and skilled health professionals anywhere in the world. Not all of them will want to participate, and it is their absolute right not to, but patients and the wider public should be reassured that assisted dying services would be commissioned and regulated in the same way as other services through the NHS, a system with which they are familiar.

There is another very important reason why I do not believe that voluntary assisted dying should be a service that is separate from the core responsibilities of the NHS. The hon. Member for East Wiltshire and others have described the decision to request an assisted death as a fork in the road. I fundamentally disagree. “Fork in the road” implies that once someone decides which route they will take, that is it: they have chosen their direction of travel. That goes completely against the principles behind the Bill.

The option of an assisted death is just that: it is an option throughout. Right up until the final moment, the person can decide not to exercise that choice. Experience from around the world suggests that consistently 30% to 40% of people do not, but knowing that they have the option has given them the comfort and reassurance that they need to make their final days less stressful and less fearful. It is crucial that the option of a voluntary assisted death remain part of an holistic approach to end-of-life care. If other options—including palliative

[*Kim Leadbeater*]

care or the comfort provided by a hospice or other institution—are working for the individual, they have no need to take it up, but if it remains their clear, settled and informed wish to do so, that is their decision.

My belief that a person requesting an assisted death should be guided through the process, in a health and care environment that they trust and are familiar with, extends to private provision. Other commissioned and regulated services are supplied by a range of providers; the same should apply in this context, as my hon. Friend the Member for Sunderland Central said.

NHS trusts and ICBs may use private providers in some circumstances, as they already do. This provides flexibility, which is important, but what matters is that the safeguards and protections in this Bill will apply no matter where the service is supplied. The same requirements on doctors will apply, including the need to prepare reports and send them to the commissioner, and the stipulation that a medical practitioner cannot benefit financially or in any material way from the death of a person and can only receive reasonable remuneration for providing the service. My new clauses 36 and 37 make provision for this. The amendments to the new clauses seek to frustrate or delay that intention, and I cannot support them.

Perhaps it is the Committee that is at a fork in the road. One route leads towards the correction of an injustice that has already lasted too long, and it offers a safe and compassionate choice at the end of life. The other route is to say that we are okay leaving things as they are, that the status quo is defensible and that people do not deserve to be given that choice.

**Danny Kruger:** I hope the hon. Lady does not really think that I or others think the status quo defensible. There are clearly major problems with our palliative care system that we all recognise and want to improve. I would be grateful if she acknowledged that we need to improve palliative care.

On the hon. Lady's point about remuneration, the Bill specifies that it would not be regarded as illegitimate for doctors to earn reasonable remuneration. What does she think "reasonable" is? How would we designate the appropriate remuneration for doctors? Does she agree that there is nothing in the Bill to stop private providers supplying the service and making money from it?

**Kim Leadbeater:** The approach to reasonable remuneration would be the same as in any other service commissioned by the NHS. There are tariffs for services that doctors provide. That is not for us in Parliament to decide; it would be up to the NHS and the commissioning bodies.

I understand that some people might be uncomfortable with private providers. If so, I suggest that they are probably uncomfortable—which might be surprising, given their politics—with the concept of private healthcare provision per se. Whatever our moral view on that is, we cannot take assisted dying out of the system that we currently have. I think it is really important that the choice is given to terminally ill patients within the framework that we have.

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

*Amendment, by leave, withdrawn.*

*Clause 32 disagreed to.*

### Clause 33

#### NOTIFICATIONS TO CHIEF MEDICAL OFFICERS

**Kim Leadbeater:** I beg to move amendment 539, in clause 33, page 19, line 34, leave out subsections (1) and (2) and insert—

“(1) The Secretary of State may by regulations make provision requiring a registered medical practitioner to notify the Commissioner of the occurrence of an event of a specified description.”

*This amendment replaces a power to make regulations requiring practitioners to notify the relevant Chief Medical Officer of certain events, including any events specified in regulations, with a power to make regulations requiring practitioners to notify the Commissioner of any event specified in the regulations.*

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

Amendment 172, in clause 33, page 19, line 34, leave out “may” and insert “must”.

*This amendment would require the Secretary of State to bring forward regulations to require any registered medical practitioner to notify the relevant Chief Medical Officer of any notifiable event.*

Amendment 540, in clause 33, page 20, line 17, at end insert—

“(2A) The Secretary of State may by regulations make provision enabling the Commissioner, by notice, to require persons (or a specified description of persons) to give the Commissioner information (or a specified description of information).”

*This amendment confers a power to make regulations enabling the Commissioner to require persons to provide information to the Commissioner.*

Amendment 541, in clause 33, page 20, line 18, leave out “subsection (1)” and insert “this section”.

*This amendment is consequential on Amendment 540.*

Amendment 542, in clause 33, page 20, line 19, leave out “the notification” and insert

“a notification under subsection (1)”.

*This amendment is consequential on Amendment 541.*

Amendment 543, in clause 33, page 20, line 20, leave out second “the” and insert “such a”.

*This amendment is consequential on Amendment 541.*

Amendment 544, in clause 33, page 20, line 22, leave out from “section” to end of line 23 and insert

“‘specified’ means specified in the regulations.”

*This amendment is consequential on Amendments 539 and 540.*

Amendment 173, in clause 33, page 20, line 24, leave out “negative” and insert “affirmative”.

*This amendment would mean that any regulations made under this section (Notification to Chief Medical Officers) must be made under the affirmative rather than the negative statutory instrument procedure.*

Clause stand part.

New clause 38—*Information sharing*—

“(1) The Commissioner may disclose information to a person within subsection (3), for the purposes of any function of either of them.

(2) A person within subsection (3) may disclose information to the Commissioner, for the purposes of any function of either of them.

- (3) The persons within this subsection are—
- the Care Quality Commission;
  - the General Medical Council;
  - the General Pharmaceutical Council;
  - the Nursing and Midwifery Council;
  - any other person specified in regulations made by the Secretary of State.
- (4) The Commissioner and the Secretary of State may disclose information to each other, for the purposes of—
- any function of the Commissioner, or
  - any function of the Secretary of State relating to the operation of this Act.”

*This new clause enables the sharing of information between the Voluntary Assisted Dying Commissioner and certain persons.*

**New clause 39—Obligations of confidence etc—**

“(1) A disclosure of information which is required or authorised by or under this Act does not breach—

- any obligation of confidence owed by the person making the disclosure, or
- any other restriction on disclosure (however imposed).

This is subject to subsection (2).

(2) This Act does not (and regulations under it may not) require or authorise the disclosure of information which would contravene the data protection legislation (but in determining whether a disclosure required or authorised by or under this Act would do so, the requirement or authorisation is to be taken into account).

(3) In this section ‘the data protection legislation’ has the same meaning as in the Data Protection Act 2018 (see section 3 of that Act).”

*This new clause provides that disclosures on information required or authorised by or under the Bill do not breach any restrictions on disclosure, but that this is subject to the data protection legislation.*

**Kim Leadbeater:** The purpose of these amendments is to enhance the effectiveness and efficiency of the notification process within the context of the Bill and to ensure that the commissioner, who plays a key role in monitoring and reporting, receives the necessary information to fulfil their duties effectively. The amendments will empower the Secretary of State to make regulations that require registered medical practitioners to notify the commissioner of any events specified. This change is a critical step towards centralising the notification process and will ensure that the commissioner is directly involved in overseeing these events in a manner that supports the broader goals of the Bill.

Under the amendments, the Secretary of State will have the authority to make regulations that require medical practitioners to notify the commissioner and that grant the commissioner the power to request information. They are designed to enhance the commissioner’s ability to effectively monitor the operations of the Bill.

New clauses 38 and 39 are designed to facilitate the proper and secure exchange of information between the commissioner, various regulatory bodies and the Secretary of State in relation to the voluntary assisted dying framework. These provisions are critical to ensuring that the operation of the Bill is transparent, effective and within a secure, legally compliant framework.

New clause 38 seeks to create a structured system for the exchange of information between the commissioner and key bodies involved in healthcare regulation and oversight. This is an essential provision to ensure that

all relevant parties can co-operate in the administration of the Bill and that the commissioner has access to the necessary data to fulfil their duties effectively.

New clause 39 addresses a critical issue regarding the disclosure of information under the Bill. It will ensure that information can be shared as required without compromising data protection laws or breaching confidentiality obligations; it seeks to ensure that while the Bill facilitates necessary data sharing, it will not override the existing protections for privacy and confidentiality. That is crucial both for the professionals and for the individuals involved in the processes established by the Bill.

New clauses 38 and 39 will ensure that the voluntary assisted dying commissioner can effectively share information with key bodies while maintaining strict adherence to confidentiality and data protection laws.

**Rebecca Paul:** I rise to speak briefly to amendments 172 and 173, in my name, but amendment 172 will fall if amendment 539 is voted through. The point of amendment 172 is to ensure that the commissioner has adequate data about important events. It turns a “may” into a “must”. It means that the Secretary of State must issue regulations requiring a doctor to notify the chief medical officer, or the commissioner as in all likelihood it will be, of any notifiable event.

3.30 pm

I note that amendment 539 would entirely remove subsection (2), which lists what constitutes a notifiable event. Gone, therefore, is the list of the minimum that must be included: the witnessing of a first declaration, the first assessment, the second assessment, the second declaration, a refusal to make a statement and so on. That seemed a reasonable list to me and I am not sure why it should be removed and the decision left to the Secretary of State. It seems to be a watering down of the type of event that must be notified, as the amendments allow much more discretion about what is requested. It seems eminently sensible that a doctor should notify the commissioner of all the various stages of the process. However, that is unlikely to be the case now—with or without my amendment.

**Kim Leadbeater:** I will double-check, but I am pretty confident that those reporting mechanisms are covered elsewhere in the Bill. I am very happy to confirm, but I think they are covered in clauses 7 and 8.

**Rebecca Paul:** It would be reassuring if that were the case because such data can be very useful. By making sure we get into the routine of providing it, it is there if we ever need it.

Amendment 173 provides that any regulations under the clause must be made under the affirmative rather than the negative statutory instrument procedure. In the interests of using our time well, I will not repeat the arguments that were made last week on this. However, if amendment 539 is accepted, the Bill will again defer a lot to ministerial powers and non-binding guidance and codes of practice. Under the negative procedure, Parliament is reduced to watching rather than properly participating in the decision-making process.

**Naz Shah:** I rise to speak in support of amendments 172 and 173, tabled by the hon. Member for Reigate, and against amendment 539, moved by my hon. Friend the Member for Spen Valley.

Clause 33 currently provides that the Health Secretary “may” bring forward regulations to require a doctor to report any notifiable event to the chief medical officer. That would be either the CMO for England or the CMO for Wales, according to where the assisted death takes place. The clause lists those notifiable events, such as the first declaration, the two statements by the doctors, including when they refuse to make such a statement, and the final statement that follows the person’s death. The weakness in the clause as originally written is its use of the word “may”. It should not be optional for the Secretary of State to make such regulations. Amendment 539 retains that weakness, while adding what I view as a new problem. The new weakness is that the amendment removes the requirement for doctors to notify the CMO of the events. Instead, it specifies that they should notify the voluntary assisted dying commissioner.

By all means let us have doctors reporting these events to the commissioner, but they should still be required to report the events to the chief medical officers too. There are at least two good reasons for that. First, the chief medical officers are extremely experienced, senior doctors. They and their staff have the ability to look at this kind of data from a medical and especially a public health perspective. The VAD commissioner will come from a legal, not medical background. They will have other abilities but they will not look at this through the lens that a senior doctor would. Secondly, it cannot be good governance that the only person who must see the data is the commissioner—the official who runs the assisted dying system and who appoints all the panel members.

**Kim Leadbeater:** I hope that my hon. Friend can take some reassurance from amendment 455, which says that

“the Commissioner must consult... the Chief Medical Officer for England”

and

“the Chief Medical Officer for Wales”

when making a report.

**Naz Shah:** I will come on to that point.

As I have said previously, this Bill will not just create a VAD commissioner, but give them the power to assess their own work. That means it is much less likely they will critically assess the data for any signs of a major problem. We all suffer from unconscious bias, even the very senior legal officials who will be eligible to become VAD commissioners. If the data were sent to the chief medical officers as well as the commissioner, that would mean two sets of officials with different perspectives and fields of expertise looking for problems. We would have a much better chance of locating problems earlier that way.

Amendment 172 would change the clause so that the Health Secretary must bring forward such regulations. As things stand, regulations brought forward under the clause would be subject to the negative procedure, which, as all hon. Members know, considerably reduces the amount of parliamentary scrutiny they receive.

Amendment 173 would make regulations under the clause subject to the affirmative procedure. I honestly try to see the arguments for and against each amendment, but I have real difficulty in seeing what the arguments against these two might be. Clearly, notifiable events are important information that must be collected nationally for a transparent assisted dying system. Equally, they need to be governed by regulations so that all doctors participating in the scheme have a clear picture of their responsibilities.

Finally, on such an important matter, Parliament should be required to vote to accept such regulations, as that will increase the scrutiny from both this House and the other place. I appreciate that my hon. Friend the Member for Spen Valley drew my attention to her amendment, which says the commissioner must consult the chief medical officer. However, it does not specify whether the consultation should include data or if it is the beginning of the process; those things are not stated on the face of the Bill. That leaves it open to interpretation, which is why I support the amendments tabled by the hon. Member for Reigate. I thank her for tabling those two very sensible amendments and I urge hon. Members to vote for them. From my perspective, amendment 539 weakens the Bill and we should vote against it.

**Stephen Kinnock:** These amendments seek to ensure that the voluntary assisted dying commissioner receives the necessary information to fulfil their functions in monitoring the operation of the Bill. Amendment 539 empowers the Secretary of State to make regulations requiring registered medical practitioners to notify the commissioner, instead of the relevant chief medical officer, of any event specified in such regulations. That could include the events currently listed under clause 33(2), such as where a practitioner carries out a first or second assessment and provides or refuses to provide a supporting statement. Setting out these events in regulations would allow for greater flexibility.

Amendment 540 empowers the Secretary of State to make regulations enabling the commissioner to require persons or specified descriptions of persons to provide information. For example, this could be access to medical records to inform panel deliberation. The regulations made by the Secretary of State under amendments 539 and 540 may also provide for how such regulations are to be enforced. The enforcement mechanism would help ensure compliance regarding the notification of provision of information to the commissioner under the regulations. Amendments 541 to 544 are consequential amendments.

I turn to amendment 172. As introduced, clause 33(1) provides that

“The Secretary of State may, by regulations, require any registered medical practitioner to notify the relevant Chief Medical Officer of any notifiable event.”

A list of such events is provided in clause 33(2). The effect of amendment 172 would be that the Secretary of State would instead be required to make regulations under clause 33(1), requiring any registered medical practitioner to notify the CMO of any notifiable event. Amendment 173 would require any regulations under clause 33 to be made under the affirmative procedure, rather than the negative procedure, meaning that they would be laid before and approved by both Houses of Parliament.

The purpose of new clause 38 is to allow the sharing of information between the voluntary assisted dying commissioner and certain persons. It would create an information-sharing gateway between the voluntary assisted dying commissioner and the Care Quality Commission, the General Medical Council, the General Pharmaceutical Council and the Nursing and Midwifery Council. The new clause includes a regulation-making power for the Secretary of State to specify any other person that the commissioner may share information with and vice versa. It also creates an information-sharing gateway between the commissioner and the Secretary of State, to enable the sharing of information for the purpose of any function of the commissioner, or any function of the Secretary of State, relating to the operation of the Bill.

New clause 39 provides that where there is a disclosure of information that is required or authorised under the Bill, it will not amount to a breach of confidence or any other restrictions placed on the disclosure of information. The new clause makes clear that data protection legislation still applies and will need to be complied with. It is essential that any provisions under the Bill that require data to be shared do not undermine the public's trust, security and privacy in terms of their personal data. I hope that those observations will be helpful to the Committee.

*Question put*, That the amendment be made.

*The Committee divided*: Ayes 19, Noes 3.

#### Division No. 71]

#### AYES

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

#### NOES

Kruger, Danny	Paul, Rebecca
Olney, Sarah	

*Question accordingly agreed to.*

*Amendment 539 agreed to.*

*Amendments made*: 540, in clause 33, page 20, line 17, at end insert—

“(2A) The Secretary of State may by regulations make provision enabling the Commissioner, by notice, to require persons (or a specified description of persons) to give the Commissioner information (or a specified description of information).”

*This amendment confers a power to make regulations enabling the Commissioner to require persons to provide information to the Commissioner.*

Amendment 541, in clause 33, page 20, line 18, leave out “subsection (1)” and insert “this section”.

*This amendment is consequential on Amendment 540.*

Amendment 542, in clause 33, page 20, line 19, leave out “the notification” and insert “a notification under subsection (1)”.

*This amendment is consequential on Amendment 541.*

Amendment 543, in clause 33, page 20, line 20, leave out second “the” and insert “such a”.

*This amendment is consequential on Amendment 541.*

Amendment 544, in clause 33, page 20, line 22, leave out from “section” to end of line 23 and insert ““specified” means specified in the regulations.”

*This amendment is consequential on Amendments 539 and 540.*

Amendment 219, in clause 33, page 20, line 24, leave out subsection (5).—(*Kim Leadbeater.*)

*See the statement for Amendment 188.*

3.45 pm

*Clause 33, as amended, ordered to stand part of the Bill.*

### Clause 34

#### MONITORING BY CHIEF MEDICAL OFFICERS

**Kim Leadbeater**: I beg to move amendment 382, in clause 34, page 20, line 26, leave out “relevant Chief Medical Officer” and insert “Commissioner”.

*This amendment provides for monitoring, investigation and reporting functions under Clause 34 to be carried out by the Voluntary Assisted Dying Commissioner (instead of the Chief Medical Officers for England and for Wales).*

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

Amendment 383, in clause 34, page 20, line 29, leave out “the relevant national authority” and insert “an appropriate national authority”.

*This amendment is consequential on Amendment 382.*

Amendment 384, in clause 34, page 20, line 30, leave out “relevant national” and insert “appropriate national”.

*This amendment is consequential on Amendment 382.*

Amendment 385, in clause 34, page 20, line 31, leave out “relevant Chief Medical Officer” and insert “Commissioner”.

*This amendment is consequential on Amendment 382.*

Amendment 449, in clause 34, page 20, line 32, after “to” insert

“Parliament or Senedd Cymru as appropriate and”.

*This amendment requires the relevant Chief Medical Officer to submit an annual report to Parliament or the Senedd Cymru and the relevant national authority.*

Amendment 386, in clause 34, page 20, line 32, leave out “the relevant” and insert “each appropriate”.

*This amendment is consequential on Amendment 382.*

Amendment 387, in clause 34, page 20, line 34, leave out “relevant Chief Medical Officer’s” and insert “annual”.

*This amendment is consequential on Amendment 382.*

Amendment 389, in clause 34, page 21, line 1, leave out subsections (3) to (7) and insert—

“(3) An appropriate national authority must—

- (a) publish any report received under this section,
- (b) prepare and publish a response to any such report, and
- (c) lay before Parliament or Senedd Cymru (as the case may be) a copy of the report and response.

(4) In this section “appropriate national authority” means the Secretary of State or the Welsh Ministers.”

*This amendment is consequential on Amendment 382.*

**Kim Leadbeater:** Amendment 382 and the consequential amendments provide for monitoring, investigation and reporting functions under clause 34 to be carried out by the voluntary assisted dying commissioner. The commissioner will submit an annual report to the appropriate national authority—Parliament or the Senedd—on the operation of the Act, as set out in amendment 389. The appropriate national authority must publish any report received under this section, prepare and publish a response to any such report, and lay before Parliament or Senedd Cymru a copy of the report and the response. I think the Committee is in agreement about the importance of reporting and monitoring under the Act, and I hope it can support these amendments.

**Danny Kruger:** I appreciate that the amendments are necessary for the new design of the Bill, but I want to express my concern that they establish an assisted dying regime that is left to monitor itself. When the person who facilitates these profound decisions is also the one who reviews them, it threatens not just the integrity of the system but the safety and trust of those it serves. Without labouring the point, other jurisdictions have significant problems with reporting and the information being the responsibility of those delivering the service. In Oregon, where assisted dying has been legal since 1997, the state relies on doctors to self-report compliance. We are left trusting that every form filled in will tell the whole story.

Robert Clark, the former Attorney-General of Victoria, is very concerned about the operation of the legislation in Australia. He has highlighted how the voluntary assisted dying review board, which is a similar arrangement to the commission proposed here, relies on paperwork from the doctors themselves, with no routine audits or real-time checks. He pointed out that a tiny group of doctors—in fact, only 10—handled 55% of all cases in 2023–24, according to the review board’s data. Many of those doctors were advocates for the legalisation of the programme. I am concerned about the implications of a system that effectively trusts doctors to provide information without any proper review.

Lastly, with all due respect to whoever comes in as commissioner, the replacement of the chief medical officer with the commissioner represents a downgrading of the scrutiny the Bill offers. We know that the commissioner is likely to be a retired judge, which is a very distinguished position, but they will not be somebody with the serious political status of the chief medical officer. The CMO role is equivalent to a permanent secretary. I am sure the hon. Member for Spen Valley acknowledges that our current CMO is probably the best-known public servant in the country. It is very significant that we are proposing to downgrade the role fulfilled by the CMO. I do not think a retired High Court judge will have the same status.

**Kim Leadbeater:** I thought the hon. Gentleman was quite keen on a judge, but now maybe less so. I hope he is reassured by amendment 455, which requires the commissioner to consult the chief medical officer. That shows really clear intent for the post to have judicial and medical expertise and oversight.

**Danny Kruger:** I am keen on actual judges who sit in court with the full authority of a judge, not a retired judge sitting at the head of a quango very far away from the decisions made about assisted dying. Nevertheless,

I am grateful to the hon. Lady, and I appreciate the fact that there will be a duty to consult. We want to have as much input from the CMO as possible in the administration of the service.

**Naz Shah:** I rise to speak to amendment 382. My hon. Friend the Member for Spen Valley may argue that some of my criticisms of the amendment relate in particular to two other amendments she has tabled: amendments 455 and 456. Indeed, I took an intervention on the matter earlier. I have read those amendments and they do not answer my concerns about amendment 382. They were grouped with amendment 382 until this morning, when the grouping was changed, so I will address them in my next speech.

This is a good moment to pay tribute to the Committee Clerks for their extremely hard work. I thank them for the way they have coped with the complex groupings and huge numbers of amendments that are unprecedented for a private Member’s Bill in this century.

My hon. Friend’s explanatory statement gives a clear explanation about what amendment 382 does. It provides for the monitoring, investigation and reporting functions under clause 34 to be carried out by the voluntary assisted dying commissioner instead of the chief medical officers for England and Wales. I can think of two possible arguments in support of it. I do not know whether either was behind my hon. Friend’s decision to table the amendment, but they are certainly the best to my mind.

The first argument in favour is that the chief medical officers for England and Wales already have a great many demands on their time. Members might say that we should not risk overloading them and should instead give another official the responsibility of looking at how assisted dying systems work. The second argument in favour is that the amendments to the Bill create a voluntary assisted dying commissioner, and that person and their officials will build up expertise in that field, so it could be argued that the commissioner would be the best person to lead monitoring, investigation and reporting.

Unfortunately I do not think those arguments hold water. On the first, it is true that CMOs have a great deal to do, but if we pass the Bill, it will be one of the biggest changes made to the duties of doctors in this country. For the first time, they will be able to help patients to take lethal drugs solely in order to bring about their death. The chief medical officers for England and Wales are senior doctors who advise Governments on all medical matters; of course they should be centrally involved in seeing whether the system works and whether there are any problems.

The second argument—that the commissioner’s office will become assisted dying subject matter experts—does not stand up either. It is true that the commissioner and the officials they recruit will come to know a great deal about the system they set up, but the very fact that they will set up and run the system means they should not take the lead on monitoring, investigating and reporting. That would mean that the commissioner and their staff would be the first people who decide whether they are doing a good job. Asking people to mark their own homework is a really bad way to check that any system is working properly. It is not how we inspect and report on schools; Ofsted has that job, not headteachers or local councils. It is not how we regulate banks, which are overseen by independent authorities.

**Rachel Hopkins** (Luton South and South Bedfordshire) (Lab): On my hon. Friend's point about marking one's own homework, does she agree that many public bodies do a self-assessment that is then looked at by the regulator? It is as important a part of the process of self-regulations as external inspection.

**Naz Shah:** As far as I have seen, no regulatory system has been proposed in regard to the Bill. I am happy to be corrected. Yes, in other instances we have regulators, but in this instance no regulator is specified. That is why I will come back to my argument about the amendment, but I value my hon. Friend's intervention.

This is not how we regulate banks, which are overseen by independent authorities. We have seen what happens when there is light-touch regulation. Banks told us all that they were doing a great job until it turned out that they were not. There is an Independent Police Complaints Commission—I could go on, as the list is very long, but I hope we can all agree on the principle. When we regulate an important system in this country, we should not allow the people who run it to be the only people to tell us whether it is working as it should. Although we respect the highly skilled people who run our schools and police our streets, we have independent people whose job it is to check whether there are any major issues.

The assisted dying system created by the Bill is both complicated and, potentially, very dangerous. If the system gets things wrong, it will mean that people will be given lethal drugs who should not have had them. That is why I would strongly support keeping the chief medical officers as the people who run monitoring, investigating and reporting. Perhaps there could be a dual system in which both the CMOs and the VAD commissioner have some kind of role. That would at least be an improvement on allowing the assisted dying commissioner to say, "There's nothing to see here." In my view, the best choice would be to retain the system that the Bill started out with and keep the chief medical officers as the people with the main responsibility for oversight.

Members disagreed with my comparison of assisted dying with the scandal of what happened to the sub-postmasters and mistresses, but we have to think about what we have learned about the causes of that scandal. Under the law, Ministers had responsibility for the Post Office. Even though it was an arm's length responsibility, they still had it. When complaints about the Horizon IT system, and then complaints about miscarriages of justice, started to come through to MPs, Ministers asked the experts in the field. Who were those experts? The executives who ran the Post Office and the engineers at Fujitsu who had set up and then run the Horizon system. What did those experts say for about 15 years? That there were no serious problems with Horizon, that the sub-postmasters and mistresses who said otherwise were lying and that all their convictions were safe. We know how that turned out.

That surely leads us to a clear lesson: we cannot ask powerful people who have created and are in charge of a system—in this case, the assisted dying system—to be the ones who report on it. I am not saying that we would see a deliberate cover-up, as there seems to have been in the Post Office scandal. What I am saying is that we all

have unconscious biases and all of us are biased to think that the work we do is good and that there are no serious problems with it.

Amendment 382 significantly weakens the version of the Bill that was presented to the House on Second Reading. We are being asked to let the commissioner report on their own work. That makes it much less likely that we would be able to spot any problems with the assisted dying system at an early stage. I therefore urge Members to vote against the amendment.

**The Minister of State, Ministry of Justice (Sarah Sackman):** It is a pleasure to serve under your chairship, Mrs Harris. I will speak first to lead amendment 382 in the name of my hon. Friend the Member for Spenn Valley, and then to consequential amendments 383 to 387 and 389, on which the Government have worked with the Bill's promoter.

As the Committee will know, the Bill currently requires the relevant chief medical officers to submit an annual report to the relevant national authority. The amendments would require that the monitoring, investigation and reporting functions under clause 34 are carried out by the voluntary assisted dying commissioner, as opposed to the chief medical officers for England and for Wales, as currently drafted. The functions are to "monitor the operation of the Act, including compliance with its provisions and any regulations or codes of practice" that are developed; to investigate and report on "any matter connected with the operation of the Act", including those that have been referred to the Secretary of State or Welsh Ministers; and to "submit an annual report". The Secretary of State or Welsh Ministers would be required to lay the commissioner's annual report before, respectively, Parliament or the Senedd, and issue a formal response.

4 pm

Amendment 449, which deals with annual report duties, was tabled in the name of my hon. Friend the Member for York Central (Rachael Maskell). The amendment would additionally require the relevant chief medical officer in the Bill as drafted—not accounting for the amendments tabled by my hon. Friend the Member for Spenn Valley—to submit the annual report to Parliament for England and to the Senedd for Wales. The amendment would confer a duty on the chief medical officer for Wales that could encroach on the executive competence of the Senedd. Were the amendment to be agreed, further devolution consideration would be required.

I hope that those observations are helpful to the Committee in its considerations.

*Amendment 382 agreed to.*

*Amendments made:* 383, in clause 34, page 20, line 29, leave out "the relevant national authority" and insert "an appropriate national authority".

*This amendment is consequential on Amendment 382.*

Amendment 384, in clause 34, page 20, line 30, leave out "relevant national" and insert "appropriate national".

*This amendment is consequential on Amendment 382.*

Amendment 385, in clause 34, page 20, line 31, leave out "relevant Chief Medical Officer" and insert "Commissioner".

*This amendment is consequential on Amendment 382.*

Amendment 386, in clause 34, page 20, line 32, leave out “the relevant” and insert “each appropriate”.—(*Kim Leadbeater.*)

*This amendment is consequential on Amendment 382.*

**Naz Shah:** I beg to move amendment 450, in clause 34, page 20, line 33, at end insert—

“(1A) The relevant Chief Medical Officer must produce an annual equality impact assessment of access to both palliative care and assisted dying on the basis of—

- (a) protected characteristics as set out in the section 4 of the Equality Act 2010,
- (b) socioeconomic status,
- (c) geographical location.”

*This amendment will ensure that a full impact assessment is carried out on the access to both palliative care services and assisted dying services.*

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

Amendment 451, in clause 34, page 20, line 43, at end insert—

“(e) there were complications in the procedure.

(2A) The Commissioner’s report must include analysis of the following—

- (a) information about the patients’ diagnosis/es;
- (b) information about the patients’ prognosis;
- (c) any instances where concerns were raised about the patients’ capacity;
- (d) any instances where concerns raised about the patient being coerced;
- (e) any concerns raised by the multi-disciplinary panel;
- (f) any concerns raised by family members;
- (g) and demographic data on the patients, including socioeconomic data, information on protected characteristics; and
- (h) data obtained from the recording of the consultation.”

*This amendment would require reporting under section 34 to include various information on diagnoses, complications, concerns about capacity and other matters.*

Amendment 455, in clause 34, page 20, line 43, at end insert—

“(2A) An annual report must include information about the application of the Act in relation to—

- (a) persons who have protected characteristics, and
- (b) any other description of persons specified in regulations made by the Secretary of State.

(2B) When preparing an annual report, the Commissioner must consult—

- (a) the Chief Medical Officer for England,
- (b) the Chief Medical Officer for Wales, and
- (c) such persons appearing to the Commissioner to represent the interests of persons who have protected characteristics as the Commissioner considers appropriate.”

*This amendment requires an annual report to include information about the application of the Bill to persons with protected characteristics and other descriptions of persons specified in regulations. It also requires the Commissioner to consult the chief medical officers and persons representing the interests of those with protected characteristics, when preparing an annual report.*

Amendment 456, in clause 34, page 21, line 28, at end insert—

“(8) In this section ‘protected characteristics’ has the same meaning as in Part 2 of the Equality Act 2010 (see section 4).”

*This is consequential to Amendment 455.*

New clause 33—*Collection of Statistics (No. 2)*—

“(1) The Voluntary Assisted Dying Commissioner must ensure that the statistics specified in Schedule [Statistics to be collected] are collected.

(2) The Commissioner must publish a yearly report setting out those statistics.

(3) The Secretary of State may by regulation vary the contents of Schedule [Statistics to be collected].”

New schedule 3—*Statistics to be Collected*—

*“Characteristics*

1 The Voluntary Assisted Dying Commissioner must collect the following information about persons requesting assisted dying—

- (a) sex,
- (b) age,
- (c) self-reported ethnicity,
- (d) level of education,
- (e) Index of Multiple Deprivation based on postcode,
- (f) region of residence,
- (g) marital status,
- (h) living status (alone, with others, in a care home etc),
- (i) main condition leading to ‘terminal illness’ fulfilment,
- (j) other medical conditions,
- (k) other psychiatric/mental health conditions,
- (l) presence of physical disability, and
- (m) presence of intellectual disability.

*Health and Care Support*

2 The Commissioner must collect statistics on the following information about health and care support—

- (a) whether the person was, before the request—
  - (i) under a specialist palliative care team, and
  - (ii) under a psychiatry team;
- (b) whether following the request there has been—
  - (i) referral to specialist palliative care team, and
  - (ii) referral to psychiatry team following request.

*Information about requests*

3 The Commissioner must collect statistics on the following information about the requests for assistance—

- (a) main reason for requesting assisted dying,
- (b) any other subsidiary reason for requesting assisted dying,
- (c) any previous requests for assisted dying from that patient,
- (d) time between first request and subsequent request(s),
- (e) number of times a second opinion was requested under section 10, and
- (f) number of times the second opinion disagreed with the first.

*Information about refused requests*

4 The Commissioner must collect statistics following information about requests that are refused—

- (a) at what stage of the process was the request refused, and
- (b) reasons for refusal.

*Information about the process*

5 The Commissioner must collect statistics on the following information about the process—

- (a) time from initial discussion to first declaration,
- (b) time from first declaration to first doctor’s assessment,
- (c) time from first doctor’s assessment to second doctor’s assessment,
- (d) time from second doctor’s assessment to panel approval,



- (e) time from panel approval to second declaration,
- (f) time from second declaration to provision of assistance to self-administer lethal drugs,
- (g) time from panel approval to death (whether by lethal drug or natural causes),
- (h) duration of relationship between patient and coordinating doctor at first request, and
- (i) use of a proxy and reason for using proxy.

*Information about clinicians and pharmacies*

- 6 The Commissioner must collect statistics on the following information about clinicians and pharmacies—
- (a) number of clinicians participating, their speciality, and number of assisted deaths each carries out per year, and
  - (b) number of participating pharmacies; number of times AD drugs are dispensed.

*Information about Assisted Dying Panel processes*

- 7 The Commissioner must collect statistics on the following information about Assisted Dying Panel process—
- (a) number of applications made,
  - (b) number of applications granted and rejected,
  - (c) reasons for rejection,
  - (d) whether family members informed of proceedings,
  - (e) whether family members took part in proceedings,
  - (f) number of requests for reconsideration made,
  - (g) number of reconsideration requests granted and rejected, and
  - (h) reasons for granting requests.

*Information on approved substances*

- 8 The Commissioner must collect statistics on the following information about the approved substances—
- (a) name of drug(s) used for the assisted death,
  - (b) whether IV or oral self-administration is used,
  - (c) presence and nature of complications following self-administration of drugs (vomiting, regurgitation, seizures, regained consciousness, other),
  - (d) time from self-administration to loss of consciousness,
  - (e) time from self-administration to death,
  - (f) were emergency services called at any time following self-administration of drugs,
  - (g) location of death,
  - (h) health care professionals present at self-administration,
  - (i) non-professionals present at self-administration,
  - (j) health care professionals present at death,
  - (k) non-professionals present at death.”

**Naz Shah:** Amendments 450 and 451 were tabled by my hon. Friend the Member for York Central. Let me first set out broadly what the amendments would do. They would mean that the reports of the chief medical officers for England and Wales had to include qualitative as well as quantitative data on assisted deaths.

Subsection (2) of clause 34 says that the chief medical officer’s report “must include information about” when four different events happen: if either of the examining doctors refuses to make a statement saying that the person is qualified for assisted dying, meaning they do not pass the tests set by the Bill; if the panel decides that the person does not pass those tests; or if the co-ordinating doctor decides that the person’s final statement does not pass the tests.

Amendment 451 would add a requirement that the chief medical officers for England or for Wales would have to report on patients’ diagnosis and prognosis, any

concerns expressed about capacity or the patient being coerced, and any concerns expressed by the panel or family members. The CMO’s report would also have to include data on the patients, including socioeconomic information and their protected characteristics under the Equality Act 2010. It would also have to include information that the doctors had gathered during their consultations with people seeking an assisted death.

I anticipate Members objecting to “socioeconomic data” as the term is vague. It is important to note that the chief medical officers’ reports on other matters already make considerable use of socioeconomic data. For example, the CMO for England’s 2024 report on health in cities gave detailed information on urban populations’ socioeconomic categories. The report looked at urban populations by indices of multiple deprivation and ethnicity, and how those factors interacted with their health. The CMOs for England and for Wales are used to working with such data. Indeed, they state in reports that using that type of information is vital to understanding the health needs of different parts of the population.

We should take this approach to understanding the people who access assisted dying—who they are, where they live and which groups they belong to. [*Interruption.*]

**The Chair:** Order. We think there will be six votes in the House, so we will aim to reconvene at 17.15.

4.5 pm

*Sitting suspended for Divisions in the House.*

5.21 pm

*On resuming—*

**Naz Shah:** I was talking about amendments 450 and 451 and explaining why we should take an approach that involves understanding who the people who access assisted dying are, where they live and to which groups they belong.

We have heard frequently from some hon. Members that assisted dying in other countries is disproportionately accessed by people with above-average incomes. They have cited data from those countries as a reason why we should be reassured that the Bill will not have harmful effects on people from ethnic minorities, say, or from economically disadvantaged backgrounds. I am sure that hon. Members would want us to gather the same information in England and Wales to ensure that people with protected characteristics or from disadvantaged communities are not harmed or discriminated against.

[SIR ROGER GALE *in the Chair*]

Having covered what the amendments would do, I want to explain why they would improve the Bill. They would increase the qualitative and quantitative data in the CMO’s reports. Such data has all kinds of benefits. It can improve the training for healthcare professionals; it can also make it easier for researchers to dig into trends in the data. We can all agree that if we are to have assisted dying in this country, it must be a much more transparent process than the one that we see in Australia, for example.

[Naz Shah]

Amendment 455, tabled by my hon. Friend the Member for Spen Valley, would require the reports to include some of the information that amendments 450 and 451 would add. I will speak to amendment 455 in more detail later, but let me say that I am glad that my hon. Friend recognises the importance of reporting on protected characteristics.

Amendment 451 would oblige the chief medical officers to report on complications that people may suffer during their assisted death. I am sure all colleagues will agree that that is a vital topic for CMOs to gather data on. If we are to have assisted dying, we need to understand how often complications occur and what factors they are associated with. That information can be used to inform the decision whether to choose an assisted death. Perhaps most importantly, it can be used to reduce the number of assisted deaths in which people suffer painful complications. It will also inform our decisions in this House if we have to amend legislation or vote on regulations.

The amendment would require the commissioner to report on the diagnoses of people who apply for assisted death, which is an extremely important provision. The duty will mean that they look for patterns of diagnoses, making it very likely that the CMOs or other researchers using the same data could spot any particular conditions presented or special problems for palliative care. Identifying such problems will give us the impetus needed to look at how the NHS can improve palliative care for those conditions.

Similarly, it is important that the CMOs look at cases in which people have raised concerns about a person's capacity or about coercion. I understand that the voluntary assisted dying commissioner has a duty to report on those and other matters, but surely hon. Members agree that this issue is so serious that we cannot allow just one official to report on possible concerns. That is particularly true because the commissioner is the person who appoints panel members and rules on appeals against decisions.

I have said it before and I say it again: it is never a good idea to allow anyone powerful to mark their own homework. This is a clear case in which we need other senior officials looking at the data for signs of things going wrong. I anticipate that the Minister is very likely to say that the Government can see problems with that part of the amendment, because he has given the same response to other amendments that include the word "complications". He has said that the Government's view is that it is not clear what the word means, so we cannot use it to impose duties on doctors or others. That troubles me, and I would like to explore it in depth with him.

Actually, the Bill uses the word "complications" in the same sense as the amendment. I refer the Minister to clause 9(2)(c), which states that the assessing doctor must

"discuss with the person their wishes in the event of complications arising in connection with the self-administration of an approved substance under section 18".

I am sure the Minister will agree that if we can accept the word "complications" in clause 9 to describe unwanted or unpleasant circumstances during and after the self-administration of lethal drugs, we can accept its use in the same sense in amendment 451. If he objects to the

word outside clause 9, I would be happy to hear a detailed explanation, because it is important that we understand why.

Amendment 450, the other amendment tabled by my hon. Friend the Member for York Central, reads:

"The relevant Chief Medical Officer must produce an annual equality impact assessment of access to both palliative care and assisted dying on the basis of—

(a) protected characteristics as set out in the section 4 of the Equality Act 2010,

(b) socioeconomic status,

(c) geographical location."

I understand that my hon. Friend the Member for Spen Valley has tabled an amendment that would require the commissioner to report on people with protected characteristics, but it would only look at how those people were affected by assisted dying. That does not go far enough.

Several doctors and experts who gave evidence to this Committee feared that people might be more likely to choose assisted dying if they had no access to good palliative care. Several experts told us that access to good palliative care varies according to where someone lives. We should not just shrug our shoulders and say that it is a terrible shame that palliative care is in bad shape in some parts of the country while it is good in others.

Amendment 451 would mean that the chief medical officers and their teams use their ability and knowledge to scrutinise the assisted dying system. Their reports would help us to identify serious problems early and then deal with them. Amendment 450 would give Parliament the regular information that it needs about whether people in this country can access palliative care. If we are serious about improving people's opportunity to have good-quality care at the end of their life, we should support it. I urge hon. Members to support both amendments.

**The Chair:** I will now suspend the sitting for about three minutes.

5.29 pm

*Sitting suspended.*

5.31 pm

*On resuming—*

**Sarah Olney (Richmond Park) (LD):** It is a pleasure to serve under your chairmanship, Sir Roger. I rise to speak in support of new clause 33 and new schedule 3.

I am concerned that amendment 455 will be inadequate to maintain trust in the system. Collecting comprehensive data, such as the detailed statistics outlined, in an assisted dying regime serves several critical purposes that revolve around ensuring transparency, accountability, safety, equity and continuous improvement of the system. It is about ensuring from the very start that there is good data and learning from the paucity or the blanks in other regimes and from where they have been criticised.

The Secretary of State would have the power to amend the new schedule, but Parliament's intent and our expectation that the system will be scrutinised would be crystal clear. We need to collect data for monitoring and oversight and gather detailed information about individuals who request assisted dying, and about the

process itself. That would allow regulators to monitor how the system is functioning, which would help to ensure that the law is being applied consistently and fairly, preventing misuse or abuse.

We need to safeguard our vulnerable population. Data on characteristics such as age, ethnicity, disability and mental health conditions and on deprivation indices can reveal whether certain groups are disproportionately seeking or being denied assisted dying. That helps to identify potential coercion, discrimination or gaps in care that might drive requests, ensuring that the system protects vulnerable individuals.

For the purpose of improving healthcare and support services, information about the prior involvement of palliative care or psychiatry teams, and about referrals made after requests, highlights whether patients are receiving adequate support before opting for assisted dying. If data shows low referral rates or unmet needs, it could prompt improvements in healthcare, access or quality, potentially reducing the number of requests driven by untreated suffering.

For the purpose of evaluating the process, tracking timelines—that is to say, from initial discussion to death—and procedural steps such as second opinions and panel decisions ensures that the process is efficient yet thorough. It can reveal bottlenecks, delays or inconsistencies, allowing policymakers to refine the system for both patients and clinicians.

For the purpose of understanding motivations and outcomes, collecting the reasons for requests, refusals and complications such as drug efficacy or adverse reactions provides insight into why people seek assisted dying and how the process unfolds. That can inform public policy, clinician training and patient counselling, ensuring that decisions are well informed and voluntary.

For the purpose of ensuring accountability, data on clinicians, pharmacies and panel decisions creates a transparent record of who is involved and how often. That helps to prevent overreliance on a small group of professionals, ensures that ethical standards are upheld and allows for audits if concerns arise.

For the purpose of public trust and ethical debate, detailed statistics foster transparency, which is essential for maintaining public confidence in a sensitive and controversial practice. They also provide evidence for ongoing ethical and legal debates, enabling society to assess whether assisted dying aligns with its values and goals, and for the purpose of learning and adaptation. By analysing complications, drug effectiveness and reconsideration requests, authorities can refine protocols, such as by adjusting approved substances or dosages, to make the process safer and more humane. Long-term data collection supports evidence-based adjustments to the regime.

Almost all jurisdictions around the world have systems for reporting on people requesting and having assisted deaths. However, there is a high degree of variability in the data reported around the world; very few data items are published consistently in all jurisdictions. We have an opportunity to learn from monitoring and reporting systems elsewhere, and to put the most robust possible system in place.

Research published in *BMJ Supportive & Palliative Care* in 2022 examined in depth the data reported in jurisdictions around the world. It identified official data

reports from 16 jurisdictions in which assisted suicide or euthanasia is legal. It found that although most jurisdictions report the number of patients who die by assisted dying, only three—New Zealand, Canada and the state of Victoria in Australia—document the number of patients who make a request to die by assisted dying. The research is from 2022, so it is possible that there are now a few more jurisdictions.

Unless we know about the applications that are assessed as ineligible, we will not have adequate insight into the functioning of patient safeguards and eligibility criteria. That is a point that Dr Annabel Price made in oral evidence and in an editorial in *The BMJ* in 2015. We need to understand not just who has an assisted death, but who is ineligible and why, to understand how the safeguards are functioning.

The 2022 paper identified Colorado, Hawaii and Maine as reporting the number of patients who received assisted suicide prescriptions, but not the number of persons who actually die by their ingestion. In these jurisdictions, there is no record of how many of the patients ingested the prescribed drugs. This is stipulated in the 2021 data summary for the Colorado End-of-life Options Act, which states that the Act

“does not authorize or require the Colorado Department of Public Health and Environment to follow up with physicians who prescribe aid-in-dying medication, patients, or their families to obtain information about the use of aid-in-dying medication.”

The official statistics reported therefore

“reflect all deaths identified among individuals by prescribed aid-in-dying medication...irrespective of whether their death was caused by ingestion of medication, the underlying terminal illness or condition, or some other cause.”

These states do not appear to have a mechanism to ascertain the amount of unused assisted suicide drugs circulating within the community. The fate of many therapeutic drugs with the potential for abuse or use for fatal overdose, such as diazepam or morphine, is not monitored, but the doses and combinations of lethal drugs used in assisted suicide and euthanasia may present a heightened risk, so monitoring the fate of those drugs should be considered.

Concern about pressure on vulnerable groups warrants the detailed reporting of patient demographics. It is needed to ensure patient safety because it allows researchers and monitoring organisations to monitor trends to determine whether there is disproportionate participation among vulnerable or minority groups and, if so, why.

Even basic patient characteristics, including gender, age and ethnicity, are not universally reported in other jurisdictions. Although marital status could be an indicator of at-home support, fewer than half of reports include it. The level of education can be an indicator of socioeconomic position, but is not routinely reported by many jurisdictions.

Although we have been told that studies that have analysed routine statistics did not indicate a disproportionate use by lower socioeconomic groups, socioeconomic trends have changed over time and new evidence has emerged. For example, in Oregon, the proportion of assisted dying patients on state health aid has doubled in the past decade; it reached 79% in 2021. That indicates an increase in use over time by those in a lower socioeconomic position.

[Sarah Olney]

Similarly, an in-depth review by Ontario's coroner last year showed that those dying by their assisted death legislation, both track 1 and track 2, were more likely to be those with longer prognoses. Given the impossibility of prognostication and the pressure being brought to bear by some campaign groups for the Bill to be wider, socioeconomic data will be very important to ascertain whether there is equity of access to assisted dying and whether financial pressures, including access to benefits, are involved in areas of higher or lower uptake.

Knowing whether patients have received care from hospice or palliative care services provides an understanding of whether patients have been provided with alternative end of life care options. That information is included in fewer than one half of the reports from jurisdictions around the world, with none providing information on the duration or scope of hospice or palliative care involvement. For example, while official reports indicate that 80% to 90% of Canadian patients who have assisted deaths receive palliative care, other studies have shown that fewer than half of such patients had seen a specialist palliative care team.

It is also essential to have information about the clinicians who participate in assisted dying, because the clinical demand of assisted suicide and euthanasia is highly time-consuming, with evidence from other jurisdictions, such as an Australian study of those participating clinicians, showing that it takes 60-plus hours of work per assisted death. Understanding the number of clinicians participating in assisted dying and their speciality is important in understanding the willingness of clinicians to participate, and how the clinical demand for assisted dying is distributed across specialities and practitioners.

Information on the drugs used in assisted deaths is critical to understanding the safety and efficacy of different drugs and drug combinations. The 2022 paper found that just six jurisdictions report the drugs used to bring about patient death. There is no one drug or drug combination that has been shown to be most effective and safe for ending patients' lives. If that research existed, we would not see such variation in the drugs used. Data on complications following drug ingestion or administration is needed to understand the safety of different drug combinations, but it is rarely reported.

Even in jurisdictions where information on safety is included, missing data can be high. For example, in Oregon, data on complications is unknown in up to 70% of cases annually. Reporting the drugs used to bring about patient death, as well as information about the assisted dying process, including the time from drug ingestion or administration to patient unconsciousness and death, and the presence of complications, would enable the safety and efficacy of these drugs to be assessed.

As in many jurisdictions around the world, what I am proposing relies on retrospective reporting of data, after the patient has died. I suggest that this is the minimum standard that must be achieved. Ideally, we would also build in processes for prospective scrutiny, before the person has died, as well as formal review processes that scrutinise individual cases in more detail. Analyses from Belgium and the Netherlands, where

review processes are established, have shown that 48% of assisted deaths in Belgium, and one in five of such deaths in the Netherlands, are not reported via the official reporting system. In some cases, legal requirements are not followed.

Setting up a post-event review panel, such as happens in the Netherlands and Ontario, would improve understanding and safety. In the Netherlands, every case is reviewed by a panel, and many cases, especially the controversial ones, are published to promote education and debate. Controversial or worrying cases will occur in England and Wales if this Bill passes, and it is essential for ongoing patient safety that these are not swept under the carpet, but that there are transparent processes to understand and learn from them.

We have heard frequently in Committee that there is no evidence of harm from other jurisdictions, but we have also heard it powerfully argued that other jurisdictions do not collect the data we would need to determine that. In Oregon, information on complications following ingestion of lethal substances is missing in around 70% of cases. Robert Clark, the former Attorney-General for Victoria, has written:

“The Victorian oversight and accountability structure can best be described as one of ‘hear no evil, see no evil, speak no evil’. In other words, it appears designed for the regulator to find out nothing, investigate nothing and report nothing that could suggest that assisted dying has been anything other than an unblemished success.”

Let us not repeat those mistakes. We can lead the way in rigorous, comprehensive data collection and transparent monitoring.

Amendments tabled by the hon. Member for Spenn Valley change responsibility for oversight from the Secretary of State and chief medical officers to the commissioner. This brings a danger of bias in reporting, as there could be an element of marking one's own homework. This means that there is even more reason for complete data reporting and transparency. Ensuring that data collected is comprehensive and reporting is transparent may go some way to assuage that concern. Importantly, strengthening data collection reporting and monitoring will not make the process harder or more lengthy for the person requesting an assisted death. It just makes the system safer and stronger.

In this amendment, I am not proposing doing anything new or radical. We are simply taking the strongest aspects of what is done in other jurisdictions and bringing them together to enable the best and most comprehensive reporting in the world. All new laws have risks as well as benefit. We must identify and be open about those risks in order to learn from harms and improve onward safety. New schedule 3 will help us to achieve that.

**Naz Shah:** I rise to speak to amendments 455 and 456, tabled by my hon. Friend the Member for Spenn Valley. Under the Bill as drafted, an annual report would be issued by the chief medical officers for England and Wales. If the other amendments pass, that report will be issued by the voluntary assisted dying commissioner.

Amendment 455 will do two things, broadly speaking. Proposed new subsection (2A) states that the commissioner's report

“must include information about the application of the Act in relation to...persons who have protected characteristics”.

Amendment 456 clarifies that the definition of “protected characteristics” is the same as that used in the Equality Act 2010. Proposed new subsection (2A) also provides that the commissioner must report on any other description of persons specified in regulations made by the Secretary of State.

5.45 pm

Proposed new subsection (2B) in amendment 455 states that when the commissioner is preparing their report, they “must consult” the chief medical officers for England and for Wales, and

“such persons appearing to the Commissioner to represent the interests of persons who have protected characteristics as the Commissioner considers appropriate.”

I will come back to the part of the amendment that talks about the need to consult the CMOs, and will first talk about how the amendment deals with reporting on people with protected characteristics.

I welcome that change as far as it goes. Several witnesses who provided oral or written evidence warned that assisted dying could have a harmful impact on women, people from ethnic minorities or the disabled. Others have warned that it could have a harmful impact on people from low-income backgrounds or economically disadvantaged areas. The amendment 455 duty on the commissioner to report on people with protected characteristics would mean officials looking at outcomes for some of those groups.

As hon. Members know, the Equality Act specifies nine protected characteristics, including age, disability, race, religion or belief, sexual orientation and sex. Proposed new subsection (2B) in amendment 455 shows that the Bill’s promoter, my hon. Friend the Member for Spen Valley, recognises that assisted dying could have an adverse effect on some of those groups. Unfortunately, her amendments do not impose a duty on the commissioner to report on the Bill’s impact on people with low incomes or from economically disadvantaged areas. I regret that the Committee has rejected several amendments that would have imposed a duty on officials to report on those groups.

I agree with the intention behind proposed new subsection (2B) in amendment 455, which states that the commissioner must consult people representing groups with protected characteristics. Again, it is welcome that my hon. Friend sees that the annual reports will need to take particular account of how assisted dying affects potentially vulnerable people. Like so much in the Bill, however, the amendment gives the commissioner too much leeway to decide who represents such groups. Surely it would surely be better to give the Secretary of State the ability to specify representatives in regulations. That route would allow Parliament to have oversight of which groups the commissioner spoke to.

I understand that a new clause tabled by my hon. Friend the Member for Penistone and Stocksbridge proposes to set up a group that would advise the commissioner on how assisted dying affects disabled people. I welcome that proposal, but I also note that that leaves the commissioner with the power to decide who they will speak to about other groups with protected characteristics. Who the commissioner speaks to in order to hear the interests of women, ethnic minority groups or older people represented would be on their

own say-so. The commissioner might choose representatives who will ask difficult, well-informed questions, or they might not.

As I have said before, we all suffer from unconscious bias. One of the biases we all have is to look for evidence that what we have done is right, and that what we believe is correct. Psychologists have named that confirmation bias. We can all remember seeing that in our own lives. I therefore do not think it is a sensible approach to ask an official who runs a system to find people who will tell them whether that system might be going wrong.

Amendment 455 also deals with the chief medical officers for England and Wales. As drafted, clause 34 gives the CMO responsibility for monitoring, investigating and reporting on the assisted dying system. The amendment says only that the commissioner “must consult” the chief medical officers when preparing an annual report. That leaves an awful lot to the commissioner’s discretion. It does not say on what matters, how detailed the consultation should be, or what should happen if the CMO thinks that something is worthy of investigation but the commissioner disagrees.

All in all, the references to the chief medical officers in the amendments tabled by my hon. Friend the Member for Spen Valley seem to be a box-ticking exercise. The involvement of the CMO might lead to detailed investigations of aspects of the assisted dying system, or they might be a brief consultation. Of course, the CMOs are senior doctors and experienced public servants of very high quality. I am confident that they will always strive to do the right thing, and I am confident that the commissioner will be a senior legal figure with great integrity and knowledge of the law, but the Bill is completely vague about how the CMO should get involved in the commissioner’s report.

I have worked in the NHS, and most employees I met were highly motivated public servants, and most NHS people would always try to do the right thing, but here is an important thing that I have learned: when people are in complex situations, and when they have many tasks and not much time in which to do them, they need clear guidance. Amendment 455 and 456 do not give us that.

I think that CMOs should be the main officials reporting on the assisted dying system—as I have said repeatedly today; it is a very important point—but, since the Bill’s promoter is tabling amendments that mean that only the CMOs should be consulted on the commissioner’s report, we need clarity on what that should mean. These amendments, unfortunately, do not give that. Amendments 455 and 456 would leave us with a much weaker system of monitoring and reporting than is in the Bill as drafted, which is why I do not support them. I hope that other Members will also reject them.

**Sarah Sackman:** It is a pleasure to serve under your chairship, Sir Roger. I will turn first to the lead amendment, amendment 450, in the name of my hon. Friend the Member for York Central.

As clause 34 stands, the chief medical officer must submit an annual report on the operation of the Bill. Under amendments tabled by the promoter, my hon. Friend the Member for Spen Valley, that would be the responsibility of the commissioner. Amendment 450 would require the chief medical officer to produce an annual equality impact assessment that assesses access

[Sarah Sackman]

to both assisted dying and palliative care for those with protected characteristics, and by socioeconomic status and geographical location.

The amendment seems intended to ensure that monitoring and reporting considers the impact of the Bill on vulnerable groups. Protected characteristics are defined by reference to section 4 of the Equality Act 2010, which means that the report would need to consider the characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

The term “equality impact assessment” is not defined in the amendment or elsewhere in the Bill. While equality impact assessments are produced routinely by Government and other public bodies in order to discharge the public sector equality duty, it is not clear what type of assessment amendment 450 would require, so, in practice, there may be difficulties for the chief medical officer in understanding whether the duty has been discharged. Impact assessments are not within the purview of a chief medical officer and should be undertaken by those who are appropriately qualified to carry them out.

In addition, “socioeconomic status” and “geographical location” are also undefined in the amendment and are not defined elsewhere in the Bill. Socioeconomic status and geographical location are not of themselves protected characteristics under the Equality Act, so are not required to be considered as part of the public sector equality duty. It is not clear, therefore, what the assessment of those factors is intended to involve.

**Naz Shah:** While I appreciate that it is not necessarily a duty as defined in law, does the Minister not agree that, given the way our Government operates, we need that data to inform us, in order to improve services elsewhere? We could apply that to this Bill as well.

**Sarah Sackman:** It is right that the commissioner, in their role of scrutinising the operation and workability of the assisted dying regime, could, under the powers conferred by the Bill, look at a range of factors, and indeed at whatever they deemed relevant to discharging that exercise. The question is: what is appropriate to be defined within primary legislation? The Government’s position is that, given that all public bodies are governed by the Equality Act, due regard to all those protected characteristics would be included. However, what is not defined within amendment 450 is socioeconomic status or geographic location. If, down the line, the commissioner wanted to look at those things, they could look at them.

**Naz Shah:** From a public health perspective, we have been having a huge debate for weeks and weeks about whether or not this is a health intervention and whether it should be provided in the NHS or elsewhere. When I was a public health commissioner, we collected socioeconomic data to learn about not just protected characteristics but socioeconomic background. There are concerns that disadvantaged groups are more vulnerable. Would it not be appropriate for the Bill to address those safeguarding issues?

**Sarah Sackman:** I suggest that those are ultimately policy choices, first for the promoter, my hon. Friend the Member for Spen Valley, and then—if the regime is voted on and passed—for the commissioner. In reality,

a lot of the data that one will collect when one has due regard to the differential impact on these protected groups will in practice have a large degree of overlap with other aspects of socioeconomic disadvantage, as is so often the case in equality impact assessments.

**Sarah Olney:** I had an interesting exchange with the hon. Member for Penistone and Stocksbridge last week about socioeconomic indicators. They are in the Equality Act but have not yet been implemented. I understand that it was in the Labour Government’s manifesto to bring forward the implementation of the socioeconomic factors in the Equality Act. Given that, as I understand it, the implementation of the Bill will probably take us up to the next general election, does the Minister not think that, at some point before it is fully implemented, there will be a way of collecting the relevant socioeconomic statistics?

**Sarah Sackman:** The hon. Member is right. Section 1 of the Equality Act 2010 refers to taking into account the impact of public administration decisions on socioeconomic disadvantage. The previous Labour Government brought that provision in under that landmark Act, but it was never brought into force. She is right that the Government are looking to do that. The question is: what is appropriate for the Bill that we are considering right here, right now? From the Government’s point of view, the voluntary assisted dying commission will be subject to the Equality Act, as it stands, and it is right that there is no need to specify the carrying out of an equality impact assessment in the Bill. That assessment will, at the appropriate time, contain whatever the Equality Act requires of that public decision maker. I do not think that we need to pre-empt, through this vehicle, things that have not yet happened in other areas of legislation.

The other point is that, leaving over for the regulations and guidance that the voluntary assisted dying commission is anticipated to produce, to take into account what needs to be taken into account in order to fully understand the regime and how it is operating, can all be developed by what will ultimately be an expert body in this field, should Parliament decide to vote for it. The question in the context of the amendments is: what do the Committee and Parliament say needs to go in the Bill right now? The Government’s position is that the amendments are neither necessary nor workable in our current legal regime.

Amendment 451 seeks to further specify what is included in the commissioner’s annual report under the promoter’s amendments to clause 34. Under amendment 451, the report must contain information on where there have been complications in the procedure, and we assume that to mean the procedure relating to the self-administration of the approved substance, as I think was clarified earlier by my hon. Friend the Member for Bradford West, who referred to clause 9 in that regard. The commissioner’s report would also be required to include analysis of a specified list of matters, including the diagnosis and prognosis of persons seeking assistance, concerns raised by family members or the multidisciplinary panel, and demographic data, including socioeconomic data and information on protected characteristics.

The Government have worked with the promoter on her amendments 455 and 456. Under amendment 455, the commissioner’s annual report would be required to include information about the application of the Bill to

persons with protected characteristics and any other descriptions of persons specified in regulations made by the Secretary of State. That is the point: the regime can evolve as appropriate when we know what it looks like and how it is operating. It can even go further than some of the categories that Members have described. That may include persons from different demographics and socioeconomic backgrounds, as proposed by the amendment. The amendment would also require the commissioner to consult, when preparing an annual report, with the chief medical officers for England and Wales and others who appear to the commissioner to represent the interests of persons who have protected characteristics and who the commissioner deems appropriate.

6 pm

Amendment 456 flows from amendment 455, and inserts into clause 34 that the term “characteristics” has the same meaning as in section 4 of part 2 of the Equality Act 2010. While some members of the Committee have challenged or criticised the choice of my hon. Friend the Member for Spen Valley to substitute the voluntary assisted dying commissioner for the chief medical officer in carrying out this consultation and monitoring, as far as the Government are concerned it is a matter for the Bill’s promoter. However, I would say as a Minister in the Ministry of Justice that when there is a judicial figure as commissioner, even if that person is a retired judge, they are subject to the guidance and the ethical code of judicial conduct—one of impartiality and independence—to conduct themselves appropriately. The Committee would do well not to impugn that impartiality.

Finally, I turn to new clause 33 and new schedule 3, tabled by the hon. Member for Richmond Park, which seek to specify statistics that the voluntary assisted dying commissioner must collect and publish within an annual report. The Secretary of State would have the power to vary the contents of the schedule by regulation. As I stated earlier, amendment 382 in the name of my hon. Friend the Member for Spen Valley would require that the functions under clause 34 are carried out by the commissioner as opposed to the chief medical officers for England and Wales. Those functions include submitting an annual report on the operation of the Bill, which could already encompass the information set out in new schedule 3.

Under amendment 455, the report must also include information about the application of the Bill to persons with protected characteristics and other persons specified in the regulations. Therefore, the changed approach from my hon. Friend the Member for Spen Valley seems to, from the Government’s point of view, accomplish much of what the hon. Member for Richmond Park is seeking to do. That is all I propose to say, but I hope that it has been of assistance to the Committee.

**Kim Leadbeater:** It is a pleasure to serve under your chairship, Sir Roger. At the risk of repeating what has already been said before by various members of the Committee, amendments 455 and 456 are important amendments that further strengthen the oversight, transparency and implementation of the Bill, particularly in relation to protected characteristics.

Clause 34(1) already establishes the requirement of an annual report to be produced, but amendment 455 goes further by mandating that this report must also

include detailed information about how the Bill applies to individuals with protected characteristics. Those are the groups identified in the Equality Act 2010, such as by age, disability, gender reassignment, race, religion and others. Furthermore, the amendment ensures that the report will not only cover those protected characteristics, but any other group that may be specified in regulations set by the Secretary of State, which provides the ability to adapt and to ensure that the Bill is applied fairly to all groups as societal needs and considerations evolve.

Amendment 455 also ensures that the commissioner consults relevant stakeholders when preparing the annual report, specifically, the chief medical officers for both England and Wales, along with representatives of groups advocating for those with protected characteristics. This collaborative approach ensures that the report is as comprehensive as possible. Of course, the report will also be supported by additional details and regulations, the doctors’ reports, and the review of the Bill as set out in clause 35. As such, I am confident that the reporting mechanisms set up under these provisions provide a thorough oversight for the assisted dying process.

*Amendment 450 negatived.*

*Amendments made:* 387, in clause 34, page 20, line 34, leave out “relevant Chief Medical Officer’s” and insert “annual”.

*This amendment is consequential on Amendment 382.*

Amendment 220, in clause 34, page 20, line 36, leave out paragraphs (a) and (b) and insert—

- “(a) a report about the first assessment of a person does not contain a statement indicating that the coordinating doctor is satisfied as to all of the matters mentioned in section 7(2)(a) to (g);
- (b) a report about the second assessment of a person does not contain a statement indicating that the independent doctor is satisfied as to all of the matters mentioned in section 8(2)(a) to (e);”

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

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

—(Kim Leadbeater.)

*This amendment is consequential on NC21.*

*Amendment proposed:* 451, in clause 34, page 20, line 43, at end insert—

- “(e) there were complications in the procedure.
- (2A) The Commissioner’s report must include analysis of the following—
  - (a) information about the patients’ diagnosis/es;
  - (b) information about the patients’ prognosis;
  - (c) any instances where concerns were raised about the patients’ capacity;
  - (d) any instances where concerns raised about the patient being coerced;
  - (e) any concerns raised by the multi-disciplinary panel;
  - (f) any concerns raised by family members;
  - (g) and demographic data on the patients, including socioeconomic data, information on protected characteristics; and
  - (h) data obtained from the recording of the consultation.”

—(Naz Shah.)

*This amendment would require reporting under section 34 to include various information on diagnoses, complications, concerns about capacity and other matters.*

*Question put,* That the amendment be made.

*The Committee divided: Ayes 7, Noes 15.*

**Division No. 72]**

**AYES**

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

**NOES**

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

*Question accordingly negated.*

*Amendment made:* 455, in clause 34, page 20, line 43, at end insert—

- “(2A) An annual report must include information about the application of the Act in relation to—
- persons who have protected characteristics, and
  - any other description of persons specified in regulations made by the Secretary of State.
- (2B) When preparing an annual report, the Commissioner must consult—
- the Chief Medical Officer for England,
  - the Chief Medical Officer for Wales, and
  - such persons appearing to the Commissioner to represent the interests of persons who have protected characteristics as the Commissioner considers appropriate.”—(*Kim Leadbeater.*)

*This amendment requires an annual report to include information about the application of the Bill to persons with protected characteristics and other descriptions of persons specified in regulations. It also requires the Commissioner to consult the chief medical officers and persons representing the interests of those with protected characteristics, when preparing an annual report.*

*Amendment proposed:* 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—
- provided to them under section (Collection of information on assistance),
  - information required by regulations made under section 39B of the Births and Deaths Registration Act 1953 (Regulations: assisted dying).”—(*Sarah Olney.*)

*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.*

*Question put, That the amendment be made.*

*The Committee divided: Ayes 4, Noes 18.*

**Division No. 73]**

**AYES**

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

**NOES**

Abbott, Jack	Charalambous, Bambos
Atkinson, Lewis	Francis, Daniel
Campbell, Juliet	Gordon, Tom

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

*Question accordingly negated.*

*Amendments made:* 389, in clause 34, page 21, line 1, leave out subsections (3) to (7) and insert—

- “(3) An appropriate national authority must—
- publish any report received under this section,
  - prepare and publish a response to any such report, and
  - lay before Parliament or Senedd Cymru (as the case may be) a copy of the report and response.
- (4) In this section “appropriate national authority” means the Secretary of State or the Welsh Ministers.”

*This amendment is consequential on Amendment 382.*

*Amendment 456, in clause 34, page 21, line 28, at end insert—*

- “(8) In this section “protected characteristics” has the same meaning as in Part 2 of the Equality Act 2010 (see section 4).”—(*Kim Leadbeater.*)

*This is consequential to Amendment 455.*

*Clause 34, as amended, ordered to stand part of the Bill.*

**Clause 35**

REVIEW OF THIS ACT

**Naz Shah:** I beg to move amendment 452, in clause 35, page 21, line 30, leave out from “must” to end of line 31 and insert

“every 12 months after the passing of this Act—”

*This amendment will replace the review conducting after five years of the passing of the Act with an annual review starting 12 months after the passing of the Act.*

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

Amendment 493, in clause 35, page 21, line 31, leave out “5-year” and insert “3-year”.

Amendment 453, in clause 35, page 21, line 36, leave out subsection (2).

*This amendment is consequential on Amendment 452.*

Amendment 494, in clause 35, page 21, line 36, leave out “5-year” and insert “3-year”.

Amendment 495, in clause 35, page 21, line 36, leave out “5 years” and insert “3 years”.

Amendment 526, in clause 35, page 22, line 10, at end insert—

- “(4) A Minister of the Crown must make arrangements for—
- a motion in neutral terms, to the effect that the House of Commons has considered the report, to be moved in that House by a Minister of the Crown within the period of 14 Commons sitting days beginning with the day after the report is laid before Parliament, and
  - a motion for the House of Lords to take note of the report to be moved in that House by a Minister of the Crown within the period of 14 Lords sitting days beginning with the day after the review is laid before Parliament.”



**Naz Shah:** Under the Bill as presented on Second Reading, the Secretary of State would have to report to Parliament on how the assisted dying system was functioning, but they would do so only after the system had been in operation for five years. Under amendment 452, tabled by my hon. Friend the Member for York Central, the Secretary of State would be required to report annually on how the system was working.

The Bill's original provision for a five-yearly report was extremely surprising. The requirement on the Secretary of State to report to Parliament is a major safeguard that will prompt them and their officials to probe all the available data on the system. It will also allow Members of this House and the other place to go over that information and look for problems, should they arise, and ways to resolve them. It could be one way to identify failings in the system early. Given that we are discussing a system to allow people to take lethal drugs, that is surely what we should aim for. We cannot afford to wait through years of media reports and complaints before then having to investigate alleged problems.

If the amendment is accepted, it will not be certain that the Secretary of State's report and the scrutiny of Parliament will identify problems in a timely way, but that possibility will be increased. If we have to wait five years for a report, it is much less likely that we will spot any problems before they have had terrible consequences. I urge Members to vote for the amendment to replace the five-yearly report.

**Danny Kruger:** I concur with the points made by the hon. Member for Bradford West. I very much appreciate the presence of clause 35 in the Bill—it is helpful that we ensure a proper review—but, as the hon. Lady said, five years feels too long to wait, so I support the amendment in the name of the hon. Member for York Central, as well as amendments 493 to 495, tabled by the hon. Member for Bexleyheath and Crayford, who has suggested a three-year review period.

My simple further point is that we are potentially creating threshold legislation: once we take the step down this road, there is no going back. The Bill leaves so much open for further expansion, I suggest, but certainly for the modification and clarification of the operation of the legislation. There is a lot left for ministerial discretion, guidance and codes of practice, as we have debated, and indeed new powers have been added, including a widening of the Henry VIII power. I think, then, that it is important to bring forward the review period.

As my amendment 526 suggests, I also think it is not sufficient simply to undertake a review, even one that is annual or every three years. There must be a guaranteed right to a debate and to hold Ministers to account at the Dispatch Box, which my amendment would insist on.

Lastly, on the inherent potential for expansion due to the wide discretion that the Bill still gives future Ministers, my concern is that the review itself might become a Trojan horse for further expansion, because that is what we see in other countries. It is held out as a safeguard, and that is exactly how we should regard it—I hope it will be that. Having a proper debate and proper ministerial accountability will allow us to check the operation of the Bill thoroughly and enable Parliament to keep it under very close scrutiny.

6.15 pm

There is a danger, though. As we have heard from Australian and American practitioners, the reviews undertaken in other jurisdictions are actually used to unpick safeguards, which become reframed as barriers to access. That is indeed implicit in a Bill that creates a new human right. The safeguards that are created discriminate against certain groups of people: most obviously, those who have a diagnosis of more than six months, those who have to go through the hoops—the number of assessments—set by the Bill, or those to whom the doctor was not able to make the suggestion directly, although we do cover that in the Bill. So the safeguards in the Bill, weak as they are in my view, nevertheless might be challenged in the course of the review. If that is what happens, that is what happens, but that is all the more reason why it is important that we insist on regular and short-term reviews, and why Parliament should have a meaningful debate with Ministers answering for the operation of the legislation.

**Daniel Francis (Bexleyheath and Crayford) (Lab):** It is a pleasure to serve under your chairship, Sir Roger. This has been a long process, and we are nearly at the end of it now. Members will recall that at the start of the process, I was very insistent that Mencap should give oral evidence. When it did so, Dan Scorer said:

“Clause 35 is about the review of the Act. The lived experience of people is absolutely vital to that. The Bill says that it will be five years until we have that review. Our view is that that is far too long. If the Bill becomes law and if there are really serious issues and discrimination taking place against people, we will want to know that a lot earlier than in five years' time, and we will want action to be taken. Our suggestion is that review should be earlier. We would want to see strong representation from patient groups across that, as well as from people who have been involved in the process, such as family members, advocates and clinicians to make sure that if serious issues are being raised, they can be picked up early and addressed.”—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 30 January 2025; c. 280, Q367.]

**Jake Richards (Rother Valley) (Lab):** My hon. Friend is, as ever, making really important points. Is he reassured by the fact that the commissioner will be reporting annually, as per the previous clause, and that the panel will give reasons, which will likely be public?

**Daniel Francis:** The annual reporting does give us some reassurance, but when we accepted some of Mencap's recommendations last week, I said that I would welcome it if the entirety of its recommendations were accepted—and it wanted an overall review at an early stage in the process.

Amendment 493 to 495, in my name, address those concerns. A consistent concern of mine is how we address issues that come to light from specific communities, particularly those with learning difficulties, and amend the legislation at a reasonable stage in the process.

**Lewis Atkinson (Sunderland Central) (Lab):** It is a pleasure to serve under your chairmanship, Sir Roger. I will be brief.

I am in favour of retaining the Bill as it stands. The key thing is the interplay between this clause and clause 42, on commencement. I would have been minded to support

[*Lewis Atkinson*]

changes to the reporting period had the Bill been commencing within two years, as clause 42 as drafted sets out, but my hon. Friend the Member for Spen Valley has tabled an amendment that will change the backstop of the commencement period to four years. The timescales set out in this clause are from the day on which the Bill is passed. It makes no sense to carry out a formal review of the operation of the legislation before the services have come into being. We will have a four-year timetable, potentially, for the backstop of the commencement. Throughout that time, the annual reporting requirement of the commissioner, who will undoubtedly have been appointed in advance, will kick in.

I also draw the Committee's attention to new clause 35, tabled by my hon. Friend the Member for Penistone and Stocksbridge, which speaks to some of the concerns raised by my hon. Friend the Member for Bexleyheath and Crayford. I strongly support the new clause, and the establishment of a disability advisory board to report annually on the effect on disabled people of not just the Act but the implementation. Picking up any concerns or views about its effect on people with disabilities would happen in a timely manner under new clause 35.

**Kim Leadbeater:** My hon. Friend makes a really important point, which I will come to in due course, but the thing that we need to analyse is the operation of the Bill. That will not start with the passing of the Bill; it will start with its commencement. It is important that we join the dots between the relevant clauses.

**Lewis Atkinson:** That is exactly right. For those reasons, I think we need to retain the full five-year review period. As my hon. Friend the Member for Rother Valley outlined, the review of the Act by the Secretary of State will be in addition to the annual reporting from the commissioner and, if we accept new clause 35, in addition to annual reports from the disability advisory board. Clearly, over the course of multiple amendments, we will have strengthened the reporting requirements both in advance of and post implementation.

**Stephen Kinnock:** It is a pleasure to serve under your chairship, Sir Roger. Amendments 452 and 453 would amend the review provisions in clause 35. As the Bill stands, clause 35(1) provides that the Secretary of State must undertake a review of the operation of the Bill and lay a report before Parliament. This is a one-off obligation that must take place after a period of five years, beginning from the date the Bill is passed. Amendment 452 would amend that requirement, and instead require the Secretary of State to undertake a review, and prepare and publish a report every 12 months after the passing of the Bill. Amendment 453 would remove the definition of the initial five-year period and is consequential on amendment 452.

That increased frequency of reporting would naturally increase the administrative burden and cost of the Bill. It is also noted that there will be an implementation period following Royal Assent. It is unclear if the intention is to require the Secretary of State to undertake a review of the operation of the Bill and prepare a report during this implementation period.

**Naz Shah:** I am surprised by what the Minister says on the cost of the Bill. My understanding from our debates on cost is that, if the Bill is passed, its cost will be footed. Why is there a cost implication to this amendment and not to other provisions?

**Stephen Kinnock:** I make these comments without a value judgment; it is simply a statement of fact that an increase in the amount of reporting, and the time and resource that that would take, would inevitably lead to a cost. I make no value judgment on that; I am merely here to point out to the Committee the Government's view on all aspects of the Bill's technical implementation, and the consequences of any changes that the Committee may wish to make to it.

Amendments 493 to 495 would change the period after which a review of the Bill is required from five years to three years. As I mentioned, clause 35 provides that the Secretary of State must undertake a review of the operation of the Act and lay a report before Parliament within 12 months of the end of the five-year period after the Bill is passed. The amendments would instead require the review of the operation of the Act and the preparation and laying of the report to take place within 12 months of the end of the three-year period that immediately follows the day on which the Bill is passed. [*Interruption.*]

**The Chair:** Order. The sitting is suspended until 7.20 pm.

6.25 pm

*Sitting suspended for a Division in the House.*

7.21 pm

*On resuming—*

**Stephen Kinnock:** Amendment 526 would impose a duty on a Minister to arrange for the report on the review of the operation of the Act to be debated by both the House of Commons and the House of Lords within 14 sitting days, beginning with the day after the laying of the report. That goes further than laying the report before Parliament as currently required under clause 35. I hope those observations were helpful.

**Kim Leadbeater:** I will speak briefly to this clause, because some of what I say will be covered in our debate on other clauses. The title of the clause is "Review of this Act", so it is important to be clear about what we are reviewing. I am sure members of the Committee agree that it is the operation of the Act that needs to be considered. As such, it is important to join the dots between the relevant clauses of the Bill and differentiate between the passing of this legislation and the commencement of its provisions.

I have tabled amendment 548 to clause 42, "Commencement", which provides that the commencement of the provisions of the Act could be up to four years beginning with the day on which the Bill is passed. I sincerely hope it is sooner than that, but I have tabled the amendment none the less. New clause 40 provides that, until the Act is implemented, the Secretary of State must lay a report before Parliament as soon as reasonably practicable after the first anniversary of the Act being passed, with subsequent reports being laid

every six months up to full implementation. It is a comprehensive reporting system, and it is really important to look at what we are reporting on. The reality is that the commencement of the Act could be between two and four years, so a five-year review makes sense.

*Amendment 452 negatived.*

*Amendment proposed:* 493, in clause 35, page 21, line 31, leave out “5-year” and insert “3-year”.—(*Daniel Francis.*)

*Question put,* That the amendment be made.

*The Committee divided:* Ayes 9, Noes 14.

#### Division No. 74]

#### AYES

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

#### NOES

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

*Question accordingly negatived.*

**Daniel Francis:** I beg to move amendment 491, in clause 35, page 22, line 2, after “health” insert “and care”.

*This amendment, together with Amendment 492, would broaden the scope of the assessment criteria for the Review of this Act, by referring to “health and care services to persons with palliative and end of life care needs” to provide a more holistic consideration of palliative and end of life care needs, reflecting current clinical best practice.*

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

Amendment 492, in clause 35, page 22, line 2, after “palliative” insert “and end of life”.

*See Amendment 491.*

Amendment 397, in clause 35, page 22, line 5, at end insert—

“(ba) an assessment of the impact of this Act on persons with learning disabilities, including any concerns about the operation of this Act in relation to such persons;”.

**Daniel Francis:** I will be brief. Amendments 491, 492 and new clause 28, which will be discussed when we come to the next group, have all been suggested by Marie Curie, the UK’s leading end-of-life charity. Amendments 491 and 492 are minor amendments that would broaden the scope of the required assessment of the availability, quality and distribution of palliative care services to be undertaken as part of the five-year review of the Act, by referring to

“health and care services to persons with palliative and end of life care needs”.

That provides a more holistic consideration of end-of-life care than the current drafting of

“health services to persons with palliative care needs”

and would reflect the current clinical best practice of palliative care multidisciplinary teams, incorporating both health and social care professionals. It is in line with current clinical best practice and with the written evidence that Marie Curie has supplied to us. In addition, amendment 397 is in line with many other amendments I have tabled during this process and seeks

“an assessment of the impact of this Act on persons with learning disabilities, including any concerns about the operation of this Act in relation to such persons”.

7.30 pm

**Stephen Kinnock:** This group of amendments relates to clause 35, which sets out requirements for review of the Act. Amendments 491 and 492 aim to broaden the scope of the assessment criteria for the review.

Amendment 491 would expand the scope of the report that the Secretary of State must prepare at the end of the initial five-year period to include an assessment of the availability, quality and distribution of appropriate care services, as well as health services, to persons with palliative care needs. Care services play an important role in supporting terminally ill individuals with care needs in settings such as care homes and in the community. However, it is not clear what the term “care services” would cover. It could include, for example, unpaid care, private or local authority-funded care, or non-statutory care services such as befriending.

Amendment 492 would extend the people the assessment will cover to include those receiving end-of-life care as well as those with palliative care needs. The Committee may find it helpful to note that, while palliative care focuses on improving quality of life for individuals with life-limiting illnesses at any stage, end-of-life care specifically addresses the needs of an individual in their final year. The Committee may also find it helpful to note that, under clause 2(1) as amended by the Committee, a person is considered terminally ill if their death, in consequence of an inevitably progressive illness or disease that cannot be reversed by treatment, can reasonably be expected within six months.

Clause 35(1) requires the Secretary of State to undertake a review of the operation of the Act, prepare a report on that review, and publish and lay the report before Parliament. The Secretary of State is required to do that during a period of 12 months beginning after the period of five years from the day on which the Bill is passed. Clause 35(3) provides a non-exhaustive list of what the report must set out. Amendment 397 would require that the report includes an assessment of the impact of the legislation on people with learning disabilities, including any concerns about the operation of the Act in relation to them. The amendment does not include a definition of “learning disabilities” and so may introduce legal uncertainty as to what must be included in the report. However, I note that there is an existing definition of “learning disability” in section 1(4) of the Mental Health Act 1983, which could be considered to mitigate this uncertainty if the amendment were agreed to.

**Kim Leadbeater:** Amendments 491 and 492 would expand the scope of the report that the Secretary of State must prepare at the end of the initial five-year period to include an assessment of the availability, quality and distribution of appropriate services by including care services and end-of-life care. It is not clear what “care

[Kim Leadbeater]

services” would cover, and I am concerned about the broadness of that term and the lack of a clear definition, so I am not minded to support amendment 491.

Amendment 492 would expand the population that the assessment will cover to include persons with end-of-life care needs alongside those with palliative care needs. That makes sense and, given the purpose of the Bill, the amendment seems sensible, so I am happy to support it.

On amendment 397, which would require consideration of the impact on people with learning disabilities, we have had this conversation several times with my hon. Friend the Member for Bexleyheath and Crayford. As I have said previously, he makes a very valid point with reference to this cohort of people, and as such I am minded to support the amendment.

*Question put*, That the amendment be made.

*The Committee divided*: Ayes 9, Noes 14.

### Division No. 75]

#### AYES

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

#### NOES

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

*Question accordingly negated*.

*Amendments made*: 492, in clause 35, page 22, line 2, after “palliative” insert “and end of life”.

*See Amendment 491*.

Amendment 397, in clause 35, page 22, line 5, at end insert—

“(ba) an assessment of the impact of this Act on persons with learning disabilities, including any concerns about the operation of this Act in relation to such persons;”.—(*Daniel Francis*.)

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

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

Amendment 546, in clause 42, page 24, line 18, after “Sections” insert:

“(Reporting on implementation of Act).”.

*This amendment is consequential on NC40*.

New clause 20—*Annual impact assessment of assisted dying*—

“(1) The Secretary of State must lay before both Houses of Parliament an annual report on the effect of this Act.

(2) The report in subsection 1 must include an analysis the effect of this Act on people’s access to—

(a) healthcare,

(b) palliative care, and

(c) assisted dying.

(3) For the purposes of subsection 2, the analysis must include an examination of people’s access by reference to—

(a) protected characteristics, and

(b) socioeconomic status.

(4) The first annual report is to be laid before each House on their first sitting day after one calendar year from the passing of this Act.

(5) Each subsequent report is to be laid on the first sitting day one calendar year after the preceding report.”

*New clause 28—12-month Assessment of this Act—*

“(1) The Secretary of State must undertake, prepare and publish an assessment, within 12 months from the day this Act is passed, of—

(a) the extent to which the Act is on course to meet its aim of allowing adults who are terminally ill, subject to safeguards and protections, to request and be provided with assistance to end their own lives;

(b) the extent to which the Act is likely to meet that aim;

(c) an assessment of the state of health and care services to persons with palliative and end of life care needs and the implications of this Act on those services;

(d) any emerging concerns relating to the current or future operation of the Act; and

(e) steps the Secretary of State plans to take in response to those concerns.

(2) The assessment in paragraph (1)(c) must include the quality and distribution of appropriate health and care services to persons with palliative and end of life care needs, including—

(a) pain and symptom management;

(b) psychological support for those persons and their families; and

(c) information about palliative care and how to access it.

(3) The Secretary of State must lay any report under subsection (1) before both Houses of Parliament.”

*This new clause would require the Secretary of State for Health and Social Care to undertake an assessment of the Act within 12 months, including an assessment of any concerns and services to persons receiving palliative and end of life care and the implications of the Act on those services.*

*New clause 40—Reporting on implementation of Act—*

“(1) As soon as reasonably practicable after the end of each reporting period, the Secretary of State must prepare and publish, and lay before Parliament, a report about—

(a) progress made in that period in connection with the implementation of this Act, and

(b) the Secretary of State’s plans for implementing the Act in subsequent reporting periods (including the expected timetable for implementation).

(2) For the purposes of this section the reporting periods are—

(a) the period of one year beginning with the day on which this Act is passed;

(b) each subsequent period of 6 months (subject to subsection (3)).

(3) The sixth reporting period under subsection (2)(b) is the last reporting period.”

*This new clause requires the Secretary of State to make, publish and lay before Parliament a report about implementation of the Act resulting from this Bill. The first report must be made as soon as reasonably practicable after the first anniversary of the Act being passed, with subsequent reports being made in respect of the six subsequent 6 month periods.*

**Kim Leadbeater**: I will speak to my new clause 40 and my amendment 546. The purpose of new clause 40 is to establish a requirement for regular reports on the

implementation of the Act until all its provisions are fully implemented. This will ensure continuous oversight and transparency regarding the progress of the Act's implementation.

The new clause will mandate the Secretary of State to prepare, publish and lay before Parliament a report on the implementation and progress of the Act as soon as reasonably practicable after each reporting period. The reports must include the progress made on implementing the Act during the reporting period, and the Secretary of State's plans for implementing the Act in future periods, including an expected timetable for further implementation. The first report must be issued one year after the Act is passed, and subsequent reports are due every six months. The sixth and final report marks the conclusion of the reporting period.

The new clause is linked to amendment 546, which will ensure that new clause 40 will be brought into force immediately upon the passing of the Bill, making the reporting requirements active right from the start. This provision is crucial for maintaining accountability and for ensuring that Parliament is regularly updated on the progress of the Act's implementation and that any necessary adjustments or future plans are communicated effectively. It provides a structured timeline to track the implementation of the Act until all provisions are fully operational.

**Daniel Francis:** I wish to speak to my new clause 28, which was suggested by Marie Curie, the UK's leading end-of-life charity. The new clause is more substantive than my two amendments in the previous group. It would require an additional assessment within 12 months of the Bill being passed, with the Secretary of State required to undertake an assessment of

"the extent to which the Act is on course to meet its aim of allowing adults who are terminally ill, subject to safeguards and protections, to request and be provided with assistance to end their own lives".

Crucially, the assessment would incorporate an assessment of the current state of health and care services to persons with palliative and end-of-life care needs, and the implications of the Act for those services, including for the quality and distribution of palliative and end-of-life care services. The new clause seeks to mirror the requirement in clause 35 for an assessment after five years of the Bill passing, only within 12 months of the Bill receiving Royal Assent, in order to provide a benchmark against which the later assessment can be measured.

There has been much discussion about the relationship between the Bill and palliative and end-of-life care services. Above all, the intention behind this new clause is to ensure that, outside the proceedings of the Committee and the progress of the Bill, that relationship is properly and thoughtfully considered by Government. We have heard a range of expert evidence throughout the Committee that, despite the very high quality of palliative and end-of-life care in this country and the phenomenal efforts of the clinicians and organisations delivering it, access to that vital care is all too often inequitable and subject to a postcode lottery.

As Marie Curie stated in its written evidence, if the fundamental aim of the Bill is to offer terminally ill people choice at the end of life,

"genuine choice...cannot exist unless dying people are able to choose to receive high quality palliative and end of life care".

The sad reality is that in too many cases today people are not able to make that choice. There will most likely be consensus among us that action is needed to fix end-of-life care to ensure that all dying people can have choice and dignity, even if we disagree on whether that is most appropriately achieved on the face of the Bill or through other mechanisms.

There has also been a great deal of debate and discussion about what the impact of introducing assisted dying might be on palliative care services and reference to what might have happened in other jurisdictions. We should not leave this to chance and fool ourselves that improved access to palliative and end-of-life care would be an inevitability as a result of the debate or level of public interest in the Bill. By requiring an immediate assessment of the state of health and care services available to persons with palliative and end-of-life care needs through new clause 28, we can create a framework for accountability within this legislation and a firmer basis on which future policy and spending decisions on palliative care can be made.

It may be useful to recall that we have not had a national strategy for palliative and end-of-life care since 2008. While I appreciate that there are major policy milestones approaching, such as the 10-year health plan, that could help to address that gap, my hope is that an assessment of the quality and availability of palliative and end-of-life care services undertaken as part of the Bill can sit helpfully alongside other plans and strategies.

When introducing the Bill on Second Reading, my hon. Friend the Member for Spen Valley chose to highlight that she had

"included in the Bill a requirement for the Secretary of State to report to the House on the availability, quality and distribution of palliative care."—[*Official Report*, 29 November 2024; Vol. 757, c. 1013.]

At this point, the Bill requires such an assessment only after five years. I hope that she and other hon. Members will agree that it would be beneficial to support this new clause so that such an assessment may be undertaken within 12 months, in support of the ambition of seeing improvements in palliative and end-of-life care.

**The Chair:** For the avoidance of confusion, these new clauses will not be voted upon now. You will have the opportunity to move them formally later, when we reach them at the appropriate time in the course of consideration.

**Dr Simon Opher** (Stroud) (Lab): I find the delay of four years that new clause 40 would introduce excessive in terms of the time taken and needed to deliver the requirements to implement the Bill in legal terms. I urge the Committee to reduce that at least to three years. That would mean four six-month checks, rather than six. The reason is that we have created a thorough Bill that is ready to implement. I understand that there are some pressures on the Department of Health and Social Care, so I accept a year's delay. My worry is that a four-year delay might well take us past the next election and that the Bill will become an issue in the election.

**Daniel Francis:** That new clause was tabled within the last week. Has my hon. Friend sought advice from the Clerks? The only way that we could amend this now is

[Daniel Francis]

through a manuscript amendment, and I presume that now, at the eleventh hour, that would not be allowable. I just want to clarify the position.

**Dr Opher:** I am afraid I do not understand how we could change this. I just wanted to put on record that I feel that a four-year delay is excessive. I have nothing further to add to that, but I would be interested in the legal opinion on whether we can change it.

**The Chair:** Again, for the avoidance of doubt, a manuscript amendment at this stage would not be accepted.

7.45 pm

**Lewis Atkinson:** I rise to speak in support of new clause 40. Given the implementation period that we are talking about, the repeated and routine reporting to Parliament on progress is essential, especially for those who want to see this Bill implemented safely and properly. Nevertheless, there are people—some of whom have joined us in the Public Gallery in recent weeks—for whom that needs to be done with deliberate speed, but without any compromise on the safety and thoroughness of implementation. New clause 40 achieves that, and I commend it.

In a different world there would have been a way of us compositing new clause 28 with new clause 40, and I regret that the two are not compatible. My hon. Friend the Member for Bexleyheath and Crayford makes good points around the earlier assessment of palliative care; I do not think that is something that divides the Committee. There have been amendments tabled by many Members over the course of the Committee that have sought to improve and strengthen palliative care as part of a holistic package at the end of life. I wonder if that is something that I could work on with my hon. Friend on Report, even if it is not possible to agree to new clause 28 tonight.

**Stephen Kinnock:** The Government have worked with my hon. Friend the Member for Spen Valley on amendment 546 and new clause 40, which are consequential and linked to other amendments to clause 42, relating to the commencement of the legislation.

New clause 40 would require the Secretary of State to prepare, publish and lay before Parliament a report about progress made towards implementing the Bill, and the Secretary of State's plans for implementation in subsequent reporting periods. The reporting periods are one year after Royal Assent, and every six months thereafter, until the sixth and final reporting period. Amendment 546 provides that new clause 40 will come into force on the day the Bill is passed.

**Kit Malthouse** (North West Hampshire) (Con): I wonder whether the Minister would entertain a suggestion. I think the extension to four years is going to cause some concern and questions in the House on Report and Third Reading. Given that the Minister is committing to reporting on a six-monthly basis, it would be helpful if the House had a broad plan against which the Government were reporting on implementation. Does

the Minister think it is a good idea, on Report or Third Reading, to come forward with an outline timetable, worked up as part of the general assessment of the project?

**Stephen Kinnock:** That sounds like a sensible approach. New clause 40 sets out the report about progress made towards implementing the Bill. If I have correctly understood what he is saying, the right hon. Gentleman is looking for more flesh on the bones of what that plan should be and look like.

**Kit Malthouse:** Essentially, I was trying to point out that four years is obviously a backstop. It may well be that the Government are able to deliver the service in advance of the four-year deadline. It might be helpful at later stages of the Bill's progress—certainly in the Lords—if the Government are able to give an indication of what they think the likely timeline might be. Admittedly, there will be flexibility in there, but that might assuage some of the concern raised by the hon. Member for Stroud that four years is quite a long time. The commissioner is going to be appointed at the 12-month mark, and that might accelerate some of the work, but I think having an indication may be helpful for Members.

**Stephen Kinnock:** I get what the right hon. Gentleman is saying now: in essence, there will be different parts of the implementation period that will be done at different times. Data may take so long, training may take so long, and so on. I think what the right hon. Gentleman is asking for is a breakdown of which parts of the Bill could be implemented—

**Kit Malthouse:** An indicative timeline.

**Stephen Kinnock:** Yes. I am very happy to take that up with officials and I will come back to the right hon. Gentleman in short order.

New clause 20 would introduce a requirement on the Secretary of State to lay an annual report in both Houses of Parliament on the impact of the Bill. The report would include the effect of an assisted dying service on access to healthcare, palliative care and assisted dying, and an analysis in relation to people's socioeconomic status and protected characteristics. That report would sit alongside the existing requirement in clause 35 for a report five years after the Bill is passed. The new clause would require that the first annual report be laid before each House on its first sitting day after one calendar year from the passing of the Bill. The Committee may wish to note that, given the 12-month timeframe, the reporting requirement may start before implementation is complete.

Protected characteristics are defined in section 4 of the Equality Act 2010; however, socioeconomic status is undefined in the new clause, and is not defined elsewhere in the Bill. It is therefore not clear what the assessment of those factors is intended to involve, and it may be difficult in practice for the Secretary of State to determine whether they have fulfilled this duty.

New clause 28 would introduce a legal requirement on the Secretary of State to undertake an assessment of the Bill within 12 months of it being passed, and to publish and lay a report of that assessment in both

Houses of Parliament. The Committee may wish to note that, given the 12-month timeframe, the reporting requirement may start before implementation is complete.

Under the new clause, the assessment must cover the extent to which the Bill is on course to meet its aims; the state of health and care services for persons receiving palliative and end-of-life care; the implications of the Bill on those services; any emerging concerns relating to the operation of the Bill; and any steps the Secretary of State proposes to take in response to those concerns. That requirement is in addition to clause 35, which requires a review by the Secretary of State at the end of the initial five-year period after the Bill is passed. That new requirement is wider in scope, and would be required after one year.

Palliative and end-of-life care services are broad, holistic services, provided by a range of professionals and providers—generalist and specialist—across the NHS, social care and voluntary sector organisations. Therefore, measuring the provision is difficult, as relevant consultations and tasks are not always coded as palliative or end-of-life care. Commissioning and contracting processes do not consistently support data collection, with block contracts and grants commonplace. It is also practically difficult to identify the Bill as the catalyst of the implications on those services over the specific period, as they are affected by multiple factors.

*Question put and agreed to.*

*Clause 35, as amended, accordingly ordered to stand part of the Bill.*

### Clause 36

#### DISQUALIFICATION FROM BEING WITNESS OR PROXY

**Daniel Francis:** I beg to move amendment 454, in clause 36, page 22, line 26, at end insert—

“(e) any person who would not have capacity to request assistance to end their own life under this Act.”

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

**Daniel Francis:** Amendment 454 stands in my name, in relation to the clause on disqualification from being witness or proxy. Clause 36(2) outlines the reasons why an individual cannot be a witness or proxy: if they are a relative of the person; if it is believed they are a beneficiary of the will; if they may otherwise benefit financially; if they are a health professional who has provided treatment or care for the person; or if they have not yet attained the age of 18.

Clearly—particularly on clause 3—we have had long debates about mental capacity, and it does not state in clause 36 as is currently stands that the person who is over 18 has to have mental capacity. Therefore, as the Bill stands, someone could bring their grandmother with Alzheimer’s or dementia along and get her to sign their paperwork. My amendment simply seeks to ensure that the person who is the proxy has mental capacity. I commend the amendment to the Committee.

**Stephen Kinnock:** As drafted, clause 36 sets out individuals who are disqualified from acting as a witness or proxy. Amendment 454 would add to that list and

exclude anyone from acting as a witness or proxy who would not themselves have capacity to request to end to their own life under the Bill. This would require there to be an assessment of the capacity of potential witnesses and proxies. There is no corresponding obligation placed on medical practitioners in the Bill to assess the capacity of potential witnesses and proxies, so it is not clear how a person would request, and be provided with, the required capacity assessment.

**Kim Leadbeater:** It is right that there are some exclusions for witnesses and proxies, as set out in the Bill, but although I have no doubt that amendment 454 comes from a good place, it seems both excessive and impractical to conduct a capacity assessment on witnesses and proxies. They are not the patient who is seeking assistance under the Bill, and the role they have is functional and will be overseen by the co-ordinating doctor. The panel can also ask to hear from them if they wish. As such, I cannot support the amendment.

**Daniel Francis:** I wish to press the amendment to a vote.

*Question put, That the amendment be made.*

*The Committee divided: Ayes 8, Noes 15.*

#### Division No. 76]

#### AYES

Campbell, Juliet  
Francis, Daniel  
Joseph, Sojan  
Kruger, Danny

Olney, Sarah  
Paul, Rebecca  
Shah, Naz  
Woodcock, Sean

#### NOES

Abbott, Jack  
Atkinson, Lewis  
Charalambous, Bambos  
Gordon, Tom  
Green, Sarah  
Hopkins, Rachel  
Kinnock, Stephen  
Leadbeater, Kim

Malthouse, rh Kit  
Opher, Dr Simon  
Richards, Jake  
Sackman, Sarah  
Saville Roberts, rh Liz  
Shastri-Hurst, Dr Neil  
Tidball, Dr Marie

*Question accordingly negated.*

*Clause 36 ordered to stand part of the Bill.*

*Clause 37 ordered to stand part of the Bill.*

### Clause 38

#### POWER TO MAKE CONSEQUENTIAL AND TRANSITIONAL PROVISION ETC

*Amendment made: 222, in clause 38, page 23, line 1, leave out subsection (2) —(Kim Leadbeater.)*

*See the statement for Amendment 188.*

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

**Danny Kruger:** I do not want to take the Committee’s time, but I invite the Bill’s promoter or the Minister to make an observation about the implications of clause 38, because the power to make

“such supplementary, incidental or consequential provision...as the Secretary of State considers appropriate for the purposes or in consequence of any provision made by this Act.”

[*Danny Kruger*]

reads to me as extremely broad. Not to repeat the point ad nauseam, but I am concerned, as ever, about the degree of discretion given to Ministers—most of it under the negative procedure. I invite the promoter or the Minister to lay out, in as much detail as they are able, the purpose of this clause and what sorts of provisions it might enable.

8 pm

**Stephen Kinnock:** I thank the hon. Gentleman for that invitation. Clause 38 is a form of insurance policy that enables the Secretary of State to respond to the evolving landscape and changes that may take place, including in the implementation period—for example, to respond to issues relating to data, substances, training or the setting up of the system. It ensures that there is a safety net or fall-back position to enable the Government to make changes that might be required.

**Kim Leadbeater:** Am I correct in thinking that this is a standard procedure, and it relates to very minor amendments, such as consequential and transitional provisions? It would be used not for any big changes to the Bill but for small amendments, and it would be burdensome to put such small changes before Parliament every time they needed to be made.

**Stephen Kinnock:** That is indeed my understanding. These would be minor changes, rather than major, fundamental changes to the Bill.

**Kit Malthouse:** I have seen these clauses in standard legislation before. As I understand it, they are often put in place where new organisations are being established and there may be knock-on effects—for example, where an organisation decides to give itself a particular name or changes its name from the one that is in the Act. It tends to be those small things where powers are vested in the Minister effectively to tinker and sandpaper at the end, to get the organisational structure correct.

**Stephen Kinnock:** That is a good description of it. The wording used in the clause is “consequential and transitional provision”, which is another way of saying exactly what the right hon. Gentleman has described.

*Question put and agreed to.*

*Clause 38, as amended, accordingly ordered to stand part of the Bill.*

### Clause 39

#### REGULATIONS

**Kim Leadbeater:** I beg to move amendment 223, in clause 39, page 23, line 4, after “purposes” insert “, and

- (b) incidental, consequential, transitional or saving provision.”

*This is a standard power for regulations to include the power to make incidental, consequential, transitional or saving provision.*

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

**Kim Leadbeater:** This is a standard power for regulations to include the power to make incidental, consequential, transitional or saving provision. This is a minor amendment, and it is a standard but vital measure to ensure the legislation works effectively and cohesively.

**Sarah Olney:** The clause, when amended by amendment 545, which we will vote on shortly, brings into stark relief how much of the Bill is to be left to regulations and how little say MPs will eventually get over it. When it comes to voting on Third Reading, MPs will have little certainty on how the Bill will actually operate—so much is to be taken on trust. If, through the gaps and grey areas, people come to harm, that will be on Parliament for failing to address these issues while we had the chance.

Let us consider all the powers that the Bill creates. Clause 5 creates a power to determine what goes into the first declaration, subject to the requirements of amendment 418. Clauses 5, 8 and 19 create powers to determine the training, qualifications and experience of the medical practitioners, with no minimum floor, and we do not even know who will ultimately decide the training—that, too, is to be left to regulations under amendment 186. Clause 6 creates powers to determine the forms of proof of identity, with no requirement for those to be photographic or to prove residency.

Clauses 7, 13 and 21 create powers to determine the statements, declarations and reports required from the doctors and the applicant. Clause 11 creates powers to make regulations for the replacement of the co-ordinating doctor if they have died, are ill or are otherwise unable or unwilling. Clause 15 creates a new power to determine who can be a proxy. Clause 20 creates a power for the approval of drugs and substances to end people’s lives. Clause 28 creates a power to determine the prescribing, dispensing and transporting of approved lethal substances—the right hon. Member for North West Hampshire has called this purely administrative. Clause 29 creates a power to make regulations relating to the registration, certification and recording of deaths. Clause 30 creates a power to issue codes of practice that practitioners must simply “have regard to”.

Clause 32 will create an extraordinarily broad Henry VIII power, as we are completely in the dark as to how the assistance will actually be provided. Clause 33 creates a power to determine which events should be notified to the commissioner and how to enable the exchange of information. That is all to be decided by the Secretary of State, with the detail removed from the Bill.

All those things are to be subject to the negative procedure, except the training and qualification requirement for the first and second doctor, the codes of conduct, and the power for the Secretary of State to arrange for delivery of assisted dying. When a statutory instrument is made through the negative procedure, there is no need for a vote. The only exception, by convention, is when the Leader of the Opposition asks for one, but they understandably would not do so on a conscience issue. In practice, Parliament will never get a say on these matters. Is the Committee content with that?

Even on affirmative statutory instruments, Parliament’s say is limited to a 90-minute debate on a motion that cannot be amended. Suppose that the Secretary of State published a code of practice on the assessment of



capacity that MPs felt did not take sufficient account of mental health conditions. They would be faced with the option to vote for it despite its inadequacy, or to vote against it and risk creating a position where there are no codes of practice at all. That is an impossible position to place parliamentarians in, yet that is what the Bill does. It is a massive blank cheque to the Executive.

I say to Government Members, who I know have great faith in the Health Secretary, that according to the Interpretation Act 1978, “Secretary of State” means any Secretary of State. The powers will not necessarily be exercised by the Health Secretary; they could be exercised by another Secretary of State. Indeed, under the doctrine of ministerial delegation, they could be delegated to another Minister who is not a Secretary of State.

I make these points to illustrate that there is an issue of principle that cannot be waved away on the basis that we think someone sensible will exercise the powers. Parliamentary scrutiny matters, and I very much regret that the Bill avoids it through these wide regulation-making powers.

**Stephen Kinnock:** The Government have worked with my hon. Friend the Member for Spen Valley on amendment 223, which would broaden the regulation-making power using standard legal wording so that any regulations made under the Bill can ensure that it works effectively with other legislation.

*Amendment 223 agreed to.*

*Amendment proposed:* 545, in clause 39, page 23, line 6, leave out subsections (3) to (5) and insert—

“(3) The Secretary of State may not make a statutory instrument containing (whether alone or with other provision) regulations under section 5(3A), 8(6A), 30(3), (Voluntary assisted dying services: England) or (Voluntary assisted dying services: Wales) unless a draft of the instrument has been laid before, and approved by a resolution of, each House of Parliament.

(4) Any other statutory instrument made by the Secretary of State containing regulations under this Act is subject to annulment in pursuance of a resolution of either House of Parliament.

(5) The Welsh Ministers may not make a statutory instrument containing regulations under section (Voluntary assisted dying services: Wales) unless a draft of the instrument has been laid before, and approved by a resolution of, Senedd Cymru.”—(*Kim Leadbeater.*)

*This amendment brings together the various provisions about the procedure for regulations. It also makes regulations under clauses 5 and 8 about training, qualifications and experience, and regulations under NC36 and NC37, subject to the draft affirmative procedure.*

*Question put, That the amendment be made.*

*The Committee divided: Ayes 15, Noes 8.*

## Division No. 77]

### AYES

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

### NOES

Campbell, Juliet	Joseph, Sojan
Francis, Daniel	Kruger, Danny

Olney, Sarah  
Paul, Rebecca

Shah, Naz  
Woodcock, Sean

*Question accordingly agreed to.*

*Clause 39, as amended, ordered to stand part of the Bill.*

## Clause 40

### INTERPRETATION

*Amendments made:* 225, in clause 40, page 23, leave out line 23.

*The amendment is consequential on Amendment 545.*

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

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

*This amendment is consequential on NC21.*

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

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

*This amendment is consequential on NC14.*

**Dr Marie Tidball** (Penistone and Stocksbridge) (Lab): I beg to move amendment 518, in clause 40, page 23, line 24, at end insert—

“‘coercion’ means behaviour of a controlling or threatening character, including but not limited to emotional or financial control, or improper interference with another person’s decision-making autonomy, which is exerted by a person or organisation, with the intention of inducing that other person to make the relevant declarations or to self-administer an approved substance under this Act against that other person’s will (and ‘coerced’ is to be read accordingly);”.

*This amendment provides a definition of coercion for the purposes of the Act. The terminology of “person” and “another person” reflects that used in clause 26.*

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

Amendment (b) to amendment 518, after “person or organisation,” insert

“including where the person is in an intimate or family relationship with that other person.”.

*This would include the risk of coercion in intimate and family relationships in the definition provided by Amendment 518.*

Amendment (a) to amendment 518, leave out

“, with the intention of inducing that other person to make the relevant declarations or to self-administer an approved substance under this Act against that other person’s will”.

Amendment 519, in clause 40, page 23, line 27, at end insert—

“‘dishonesty’ means not being truthful, or not acting in good faith;”.

*This amendment provides a definition of dishonesty for the purposes of the Act. The terminology of “person” and “another person” reflects that used in clause 26.*

Amendment 520, in clause 40, page 23, line 37, at end insert—

“‘pressure’ means an act or acts, or communication, or behaviour, constituting an improper interference with another person’s decision-making autonomy, which is exerted by a person or organisation,

*[The Chair]*

with the intention of inducing that other person to make the relevant declarations or to self-administer an approved substance under this Act against that other person's will."

*This amendment provides a definition of pressure for the purposes of the Act. The terminology of "person" and "another person" reflects that used in clause 26.*

Amendment (b) to amendment 520, after "person or organisation," insert

"including where the person is in an intimate or family relationship with that other person,".

*This would include the risk of pressure in intimate and family relationships in the definition provided by Amendment 520.*

Amendment (a) to amendment 520, leave out

", with the intention of inducing that other person to make the relevant declarations or to self-administer an approved substance under this Act against that other person's will".

**Dr Tidball:** It is a pleasure to serve under your chairship, Sir Roger. I rise to speak to amendments 518 to 520, which respectively provide definitions of coercion, dishonesty and pressure for the purposes of the Bill.

In my speech on Second Reading, I said I would want to ensure that the final stages of the Bill define dishonesty, coercion and pressure. I have sketched out the definitions based on oral evidence given to the Committee, and am grateful for the extremely helpful input from Laura Hoyano and Max Hill, after the witness sessions, in establishing the content and parameters of the definitions. We have spent a considerable amount of time in Committee discussing the safeguards against coercion, for example, but I felt we had not spent much time discussing the content and parameters of the concepts. Although I will not be press the amendments to a vote, for reasons I will outline, it is important to ensure that our discussions of the concepts are on the public record.

I will not press the amendments to a vote as I am convinced, after discussions with legal colleagues and having considered the issues very carefully, that the risks of setting the parameters on the face of the Bill are too great. It would risk ossifying the courts rather than ensuring that they use the full parameters of the concepts to encompass scenarios for the offences under clause 26 in circumstances that the Committee may not currently conceive of. In other words, I am convinced that to limit the definitions of the concepts in statute would create the risk of excluding criminal behaviour where the threshold of the offence would otherwise be met under common law.

I believe that instead, mirroring the approach to coercion taken in the Serious Crime Act 2015—a point I will return to—the Ministry of Justice must draw up details of the concepts and examples of their application in the context of the offences set out in clause 26. Doing so will be helpful for the medical practitioners, along with other professionals, who use the Bill if it becomes law, and in the training to be provided for them under the Bill to enable medical practitioners to evaluate whether each patient has been subjected to coercion, pressure or dishonesty by another person in applying for assisted dying.

In criminal law, definitions of coercion, dishonesty and pressure are not placed on a statutory footing. First, on dishonesty, *Ivey v. Genting Casinos* is the lead case because there is no statutory definition of dishonesty.

The case provides not a definition but a two-stage test. The courts are familiar with the legal elements of dishonesty from case law: for a long time the part-subjective and part-objective Ghosh test was applied. That was amended in 2020 by the Supreme Court in the *Ivey* case, which disapproved the former test but retained the question: "Was his or her conduct dishonest by the standards of an ordinary decent person?"

Similarly, "pressure" does not have a statutory definition in criminal law, but essentially means forcing someone to do something against their will. Having looked at this issue carefully, I am satisfied that the wording in clause 26 is enough to signal to anyone involved in a relevant application to bring a criminal prosecution what they should look for in terms of acts and intent. The common law is thus well placed to further develop the concepts in the context of the offences set out in clause 26.

8.15 pm

I want to spend more time looking at the issue of coercion, as safeguarding against coercion has been at the forefront of our minds throughout the oral evidence process and the Committee's deliberations. Section 76 of the Serious Crime Act 2015 is the only statute that currently uses the concept of coercion, but it does not provide a statutory definition of it; instead, the 2023 Home Office guidance defined controlling or coercive behaviour, non-exhaustively, as

"acts designed to make a person feel inferior and/or dependent by keeping them apart from friends, help and support. It can include taking advantage of their money and things they have, stopping their independence, and controlling what they want to do."

As important as that Act and its associated guidance are in identifying coercion in the context of domestic abuse, that did not seem to me sufficient for understanding coercion for the purposes of this Bill. In particular, it does not create a sufficient nexus to the inducement

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

in clause 26(1), and it does not reflect the inducement in clause 26(2) to "self-administer an approved substance" by "dishonesty, coercion or pressure". That is why my definition creates a direct link to the two dimensions of the offences.

In my amendment 518, coercion means

"behaviour of a controlling or threatening character, including but not limited to emotional or financial control, or improper interference with another person's decision-making autonomy, which is exerted by a person or organisation, with the intention of inducing that other person to make the relevant declarations or to self-administer an approved substance under this Act against that other person's will".

My definition would therefore encompass individual incidents, as well as cumulative and repeated acts of behaviour that is of a controlling or threatening character.

In addition to reflecting the elements of emotional and financial control or threatening behaviour referred to in the Home Office guidance on the Serious Crime Act 2015, my proposed definition includes

"improper interference with another person's decision-making autonomy".

This is to ensure that the definition covers scenarios in which an individual's volition has been usurped by another person or organisation.

Vitiating consent to a first and second application, or to not cancel such a declaration, or to self-administer an approved substance, under the Bill, need not fit the

full definition of coercive and controlling relationships in the Serious Crime Act 2015. Thus further relevant guidance issued under codes of practice must also reflect that point—I will return to that issue shortly. I have included “organisation” in my definition because it was important to me to demonstrate our intention that organisations can be vicariously liable for the actions of their employees and officers who, in the course of their employment, induce another person by dishonesty, coercion or pressure.

Later in my speech, I will return to why fettering the definition on the face of the Bill creates greater risks than it safeguards against, but at this point I want to acknowledge amendments 518(b) and 520(b), tabled by my hon. Friend the Member for Lowestoft (Jess Asato). She proposes adding the words,

“including where the person is in an intimate or family relationship with that other person”.

In using the term “person”, my intention is deliberately broad to ensure that we maximise the scenarios that we want to be captured by the offences in clause 26. I support my hon. Friend’s principle, but believe that to narrow the provision in that way on the face of the Bill would be unhelpful. However, I absolutely agree that guidance and training on the concept should include such individuals. Indeed, I am satisfied that the clear and succinct language in clause 26—

“A person who, by dishonesty, coercion or pressure, induces another person”—

follows a standard legal formulation in the broadest possible sense to encompass the groups that my hon. Friend describes.

The ability of members of the medical profession to identify such persons was helpfully expounded on in the Committee’s oral evidence sessions. I asked Professor Nicola Ranger from the Royal College of Nursing how her members would detect coercion, undue pressure or dishonesty by family members or other supporting parties on whom the patient was relying in relation to seeking assistance. Her response was strong:

“Safeguarding is part of our professional responsibility now. Whether it is for a child, an adult or an elderly person, part of our role is to be vigilant against financial misconduct, physical abuse and mental health abuse: any of those things is a responsibility of every nurse now. It is a very good and simple process. You do not have to investigate or give a judgment; you need to refer it to be investigated. That takes the pressure off an individual clinician. Our job is to be vigilant and to refer safeguarding anywhere we think that there is any form of abuse. I think that that process would remain and could be part of how we do things now.”—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 28 January 2025; c. 55-56, Q63.]

The next element of my formulation, the “intention of inducing”, is a key foundation of our understanding of coercion under the Bill, and reflects the criminal prosecution that must follow the inducements set out in clause 26. As I have said, I tabled the amendments as probing amendments. However, I reject amendment (a) to amendment 518 and amendment (a) to amendment 520, both tabled by the hon. Member for East Wiltshire, because every criminal offence must have two elements: the prohibited act, or the *actus reus*, and the state of mind, or the *mens rea*, accompanying it, as specified.

The amendments tabled by the hon. Member for East Wiltshire would sever the link with the foundational elements of a criminal offence by removing the necessary *mens rea* element from the “intention of inducing” in

my definition. Without the intention being specified, coercion, pressure or dishonesty become offences without any context whatsoever. Training about coercion, dishonesty and pressure must enable medical practitioners to identify both the prohibited acts and the state of mind required to amount to an offence under clause 26.

I am extraordinarily grateful to Max Hill KC, Alex Ruck Keene and Laura Hoyano for their helpful input, following our oral evidence sessions, in reviewing my proposed amendments, and for their perspectives on the benefits and disbenefits of placing definitions on the face of the Bill. Alex Ruck Keene succinctly set out the risks:

“If you start trying to get precise, you run the risk of arguments that the definition is exhaustive”.

He emphasised the need for statutory guidance to address these issues.

As a consequence, and having carefully deliberated on the issues, I think the best solution is to mirror the approach to coercion in the Serious Crime Act 2015. The Act itself does not set out a definition in section 76, which deals with coercion; instead, the statutory guidance issued by the Home Office in 2023 details the concepts and gives examples of their application. In the context of the Bill, and the offences set out in clause 26, guidance on dishonesty, coercion and pressure could be drawn up under either clause 30, on codes of practice issued by the Secretary of State, or clause 31, on guidance from the chief medical officers.

Further detail could be provided in the regulations on training in respect of domestic abuse, including coercive control, as set out in amendment 22 to clause 19. Such additional explanatory notes on the concepts of dishonesty, coercion and pressure under the codes of practice or guidance from the chief medical officer would also facilitate the commissioner in ensuring that each member of the panel has training in relation to domestic abuse, including coercive control, and financial abuse, under amendment (c) to new schedule 2, which I hope we will support. Elaborating on those concepts under either clause 30 or clause 31 will be helpful for the medical practitioners using the Bill if it is to become law, and helpful with the training to be provided for them under the Bill. It will enable them and other relevant professionals to evaluate whether each patient has been subject to coercion, pressure or dishonesty by another person in seeking assistance.

In conclusion, I will not press my amendments to a vote because the risks outweigh the benefits. As I explained, explanatory notes in either codes of practice issued under clause 30, or guidance under clause 31, from the chief medical officer would work best to avoid bespoke definitions within the Bill being misapplied across criminal law more generally. I have taken on board the oral evidence we heard from witnesses, and made sure that I have carefully considered the anxiety some of them voiced that we must not stymie the statute with definitions that are too tightly drawn, thus missing important legal nuances in the scenarios that the Bill would want us to contemplate, and would require further careful guidance upon.

I urge the Secretary of State and the chief medical officers, along with the Ministers and policymakers implementing the Bill, to perceive a very clear intent when producing the codes of practice and guidance by

the chief medical officer to spell out in more detail the application of the concepts of dishonesty, coercion and pressure in the specific context of the Bill.

**Naz Shah:** I rise to speak to amendment (b) to amendment 518, and amendment (b) to amendment 520. Although I appreciate that my hon. Friend the Member for Penistone and Stocksbridge is not pressing her amendments to a vote, it is important to get a few things on the record. I am speaking to these amendments to her amendments because they were tabled by my hon. Friend the Member for Lowestoft.

Before I speak further, my hon. Friend the Member for Spen Valley, the Bill's promoter, has accepted several amendments tabled by my hon. Friend the Member for Lowestoft before—I do not know what her response is, given that my hon. Friend the Member for Penistone and Stocksbridge is not pressing her amendments to a vote. That has thrown me off track, to be fair, because I was not expecting that. Either way, let us move on.

I thank my hon. Friend the Member for Penistone and Stocksbridge for her detailed, interesting presentation to the Committee, though I am not sure I entirely agree with it. Although there might a point, from a legal perspective, where these offences actually do exist in the law, the truth remains, and the facts remain, that when it comes to domestic violence—coercion and so on, which we have debated extensively—we have put the training in, but not putting the offences on the face of the Bill slightly contradicts the conversation we had last week, when my hon. Friend the Member for Spen Valley, the promoter, specified that the sentence for somebody who is found guilty of coercion would be put on the face of the Bill; for example, if a person were found to be guilty of coercing somebody who then died, that would carry a life sentence. My understanding is that there would have been no need for the amendments on that, because we already have those laws in existence for murder, and that would be murder.

8.30 pm

**Dr Tidball:** Clause 26 puts in place the elements of the offences under the Bill. It is right that it does that and draws the parameters very tightly and firmly. Under criminal law, those concepts are defined nowhere else on the face of a statute. My severe concern, having listened to the Committee and its worries about concepts such as coercion, is that we risk restricting our understanding of the concepts too tightly, and therefore excluding cases of the kinds that we want to include. By leaving them in the Bill but not defining them, we enable the common law courts to interpret the facts on the basis of the lives of the real people that come before them. I want to make sure that, where it is right and proper that those courts interpret the law on the basis of those facts, they are able to do so and are not restricted by too limited a definition in the Bill. I want to ensure that more, not fewer, cases can be encompassed.

As I said in my speech, we have talked about these concepts in quite an abstract sense. I wanted us to ground that in the reality of what we might want guidance and further advice on those concepts to look like. That would follow the convention, as I have said already, in other areas of the law, such as domestic abuse, where the primary legislation does not define the concepts but secondary legislation provides further details and real-life examples for practitioners and the courts.

**Naz Shah:** I thank my hon. Friend for her detailed explanation. She makes sense—I would not want to restrict that either. Perhaps she is entirely correct—no doubt she has researched it well—but clause 26 mentions coercion and pressure. It says all of that on the face of the Bill. My hon. Friend wants to leave it in that context—

“by dishonesty, coercion and pressure, induces another person to self-administer an approved substance”,

which is repeated in clause 26(1) and (2). I would still be minded to put at least something further in the Bill. I am not sure that it would restrict us; it would just be helpful. If my hon. Friend does not press the amendment to a vote, would the Ministers accept that there will be statutory guidance on that? I do not know whether the Ministers can respond now or want to wait until they sum up. I am happy to give way. They are not going to bite; that is fine.

Just for the record, I want to talk through the amendments tabled by my hon. Friend the Member for Lowestoft and why she and I feel that they are important. Amendment 518 would put in the Bill a definition of “coercion”. Amendment 520 would do the same for “pressure”. Those amendments give welcome clarity to the Bill on two important issues. Where they talk about a “person or organisation” engaging in coercion or pressure, respectively, my hon. Friend's amendments would have added,

“including where the person is in an intimate or family relationship with that other person”.

That would make sure that we covered that.

**Dr Tidball:** I thank my hon. Friend for her speech. I think we are united in principle, but perhaps take different views on the best way to ensure that this happens in practice. To give an example, if the word “intimate” is used in those circumstances, were a court to interpret it, it might include a husband, wife or partner, but not a brother, sister or parent. So already, in using that one word, we have potentially created further risks. By defining it, in the circumstances set out by my hon. Friend the Member for Lowestoft, we are excluding a relationship that we would want the court to look at, to weigh and judge whether there was potential dishonesty, coercion or pressure by that person, in that relationship with the person seeking assistance. I give that as just one example of the risk created by adding language, rather than leaving it more broadly for a court to interpret on the basis of the facts of the case.

**Naz Shah:** I will re-read it. It is,

“including where the person is in an intimate or family relationship with that other person”.

The “family relationship”, I think, means that it is extended to siblings. That was my interpretation. Last week, or the week before, we spoke extensively about suicide, and women in particular. The number of women who have committed suicide, particularly following domestic violence, has increased. Indeed, it was on the front page of *The Guardian* today. It is defined by our lawmakers as intimate partner violence, but it could be other violence. In those cases, as a Government and as lawmakers, we do define those women who are killed by members of their family or intimate partners. Our Minister for Safeguarding and Violence Against Women and Girls reads out that list.

**Dr Tidball:** Alex Ruck Keene's sage words to me were that the problem with putting in more words is that it creates an opportunity for lawyers to find loopholes. In the example that the hon. Lady has just given, when we are talking about family relationships, I think we would all agree that, having thoroughly considered the evidence in this Committee, we do not want any interpretation of the offences set out in section 26 to exclude, for example, carer relationships. That is not a family member, but a carer might give close personal care to someone with a terminal illness. We do not want the courts to think that it was the parliamentary intention of the Committee to delimit it to only intimate or family relationships. There is a risk that the more we narrow it by example, rather than leaving the term broad, as it is currently—"person"—we risk delimiting it too far. We do not want to exclude a situation involving an offence that we hope would be brought before the courts for prosecution.

**Naz Shah:** I thank my hon. Friend for her explanation, which was very good. I do not have time to go away and think more about it from a legal perspective, because I have only just heard her arguments, but at the moment I absolutely agree.

As for my hon. Friend the Member for Lowestoft, I thank her for her attempt to explain. She has years of experience of working in the field. She tabled that amendment in response to the amendment from my hon. Friend the Member for Penistone and Stocksbridge, with the best of intentions and to strengthen the legislation. I will look at it, and I may even return to it during the debate.

**Danny Kruger:** That was an interesting exchange. I think I agree with the hon. Member for Penistone and Stocksbridge more than I do with the hon. Member for Bradford West, which is an uncomfortable situation for me, but I want to show that I am actually listening. I also agree with the Minister of State, Ministry of Justice, the hon. and learned Member for Finchley and Golders Green, who said last week that, without a statutory meaning, the terms "coercion" and "pressure" have their natural, ordinary meaning, which is well understood by the public and the courts alike.

I have encouraged more clarification and clarity throughout the Committee's deliberations, and I accept the point made by the hon. Member for Penistone and Stocksbridge and the Minister that we are in a good place in outline in terms of understanding these concepts. However, I agree with the hon. Members for Penistone and Stocksbridge and for Bradford West that it would be helpful to have further clarity from the Ministers. If there is guidance to come, it is important that we proceed with due respect to the points that have been made, including the proposals from the hon. Member for Lowestoft, which I agree with in principle.

However, I want to make the point behind my amendment (a) to amendment 518, tabled by the hon. Member for Penistone and Stocksbridge, even though I understand she will not push it to a vote, so I cannot push mine. She challenged me about the purpose of my amendment, so I want to explain it. There are two places in the Bill where the concepts of coercion and pressure occur: one is in the context of the assessment process for eligibility for assisted death, and the other is in terms of the criminal offence of coercion into an

assisted death. Those are two separate areas of the Bill, but they use the same terminology, and the same principle of coercion is behind them both.

The point of my amendment is to make clear the distinction between eligibility and the criminality involved in coercion. Although I entirely agree with the hon. Member for Penistone and Stocksbridge that it is appropriate to retain the principle of intention—to be clear, my amendment would remove the requirement for evidence of intention to coerce, leaving just the fact of coercion in the definition—her point was that it is important to retain evidence of intention in order for the criminal offence to be meaningful. I accept that that is a point in criminal law.

However, it is important that we do not include intention in the context of the assessment of eligibility criteria, for the simple reason that somebody may well be coerced into an assisted death in a way that we would all understand, but the perpetrator may not have had the explicit intention of that outcome. An example would be where an abusive husband, through abuse, victimisation, relentless unkindness and perhaps the direct communication of, "You'd be better off dead," has the effect of coercing his victim—his wife—into seeking an assisted death, which might well be subject to criminal prosecution on these terms. He would nevertheless be able potentially to claim that that was not his intention, and, indeed, perhaps it was not. He might not have had the explicit thought in his head, "I want to make her apply for an assisted death." Nevertheless, that is the consequence of his coercive behaviour.

I would hope that when the doctors assessed that particular case and came across evidence of that pattern of abuse, they would conclude that this person was being coerced, and would therefore not award the applicant the green light to proceed. That is an example of where it is important to remove the intention of coercion from the definition. I entirely agree with the hon. Member for Penistone and Stocksbridge about the value and necessity of including intention where we are talking about the criminal offence of inducing somebody to have an assisted death.

Lastly, let us think about this from the point of view of the doctor or panel who are being asked to approve the application. If the definition of coercion includes the intention to coerce, we are inviting—in fact, requiring—the doctor or panel to seek evidence of the intention of the person doing the coercion, rather than just the fact of the patient having been coerced. We would require them somehow to interview the abuser, so I think we would get into difficult territory if we insisted on evidence of coercion in order to deny the application on that basis.

I hope that that helps to explain the purpose behind my amendment. I know it is slightly academic, because we are not proceeding with amendment 518, but I hope the Minister and the hon. Member for Spen Valley reflect on the points made by the hon. Member for Penistone and Stocksbridge and take them on board in subsequent amendments or guidance.

8.45 pm

**Rebecca Paul:** It is a pleasure to serve under your chairmanship, Sir Roger. I rise to speak about amendments 518 and 520. As we have said, it is important

[Rebecca Paul]

that we understand what coercion means in a legal sense, and I am really grateful to the hon. Member for Penistone and Stocksbridge for trying to set that out, because it is not an easy task. Like her, I am concerned that defining it in this way may make it harder to prove coercion and may undermine the safeguards in the Bill.

Under the amendments, the assessing doctors and the panel are meant to look not just for evidence of coercion but for evidence of intent to induce assisted suicide, and they will have to show that the applicant is requesting assisted suicide against their will. That could make the law powerless against many kinds of behaviour that we want to prohibit.

To start with the point about intent, coercion and pressure take many forms, and they do not always involve a clear intent. Amendment (b) to amendment 518 and amendment (b) to amendment 520, in the name of the hon. Member for Lowestoft, very reasonably draw attention to family relationships. On Second Reading, the right hon. Member for Hackney North and Stoke Newington (Ms Abbott) said:

“people do not generally write letters to sick relatives urging them to consider assisted suicide and then put those letters on file. Coercion in the family context can be about not what you say but what you do not say—the long, meaningful pause.”—[*Official Report*, 29 November 2024; Vol. 757, c. 1030.]

But even in more blatant cases, we cannot necessarily prove intent directed towards assisted suicide. Sue Smith, a clinical psychologist, said in written evidence that coercive control often ramps up when the abused partner receives a cancer diagnosis:

“The seriousness of the cancer diagnosis may be systematically and actively denied or minimised, claims can be made by the male partner that she is attention seeking, or she is accused of making up the effects of treatment, and can be left isolated and alone when in physical need...a woman learns to doubt her reality and experience, and is extremely isolated. This can lead to heightened anxiety, hopelessness and helplessness, and abject despair, which can lead to a person wishing they were dead.”

That could be seen as coercion towards assisted suicide, but in that scenario does the abusive partner demonstrate clear intent? I am not sure the doctor or panel could demonstrate that in that instance, especially as they need to be satisfied only on the balance of probabilities that there is no coercion. If the panel think that there is a 45% chance that there is intent, but no more than that, they have to grant the application.

The harrowing story of Ryan Wellings and Kiena Dawes shows that even when coercion can be proved, proving that an abuser intends someone else's suicide is a completely different matter. After Kiena Dawes took her own life, Wellings was convicted of coercive control and assault. The judge told him:

“from May 2020 until her death you abused, assaulted, exploited, controlled and demeaned her. When she died it is clear that she had begun to believe your lies to the effect that she was deranged, physically disgusting, friendless, worthless and an unfit mother. You had persuaded her that she had no one to turn to.”

Before her death, Dawes wrote a note saying, “Ryan Wellings killed me.” Although he was convicted on other counts, Wellings was acquitted of manslaughter. That demonstrates that coercive control, even if it is followed by suicide, does not always mean that intent can be demonstrated. It is really tricky.

Similarly, people may pressurise a relative without intending to override their will. The barrister Ruth Hughes KC, who has been quoted before, said:

“It is surprisingly easy for a relative, whilst completing a variation on ‘the classic asset strip’, to persuade themselves that they are actually acting in their aunt Dorothy's best interests or in accordance with her wishes”.

In other words, someone can pressurise a relative into assisted suicide without intending to. Again, including intent here could actually muddy the waters.

I have a similar concern about the phrase “against that other person's will”.

That sounds very straightforward, but in practice it can be much less clear. Part of the effect of coercion is that people lose confidence in their own will and adopt that of others. In written evidence, many frontline workers pointed out that coercion does not always clearly appear as someone acting against their will. Janet Reiss, a specialist doctor in palliative care in Wolverhampton, says patients will not

“even necessarily be aware of being coerced”.

Dr Jennifer Harges Dvorak, a senior lecturer at Canterbury Christ Church University specialising in medical law, states that the Bill

“does not consider how people internalise feelings of coercion and...act on this.”

If someone has internalised a feeling that they would be better off dead, that may be their will, even if we hope we could change it.

Anni Donaldson, a domestic abuse expert at the University of Strathclyde, said:

“Decades of work examining the impact of coercive and controlling behaviour has shown that ‘coercive control’ is not merely persuasion, but a complete change in the perspective of the victim so that she truly believes that she is worthless, a burden to her partner or wider family, and would not be missed should she die...Women are regularly humiliated, demeaned, and told they would be ‘better off dead’, or, that they are a ‘useless mother’, or that the children would be better off without them. This abuse erodes women's confidence, autonomy, and self-esteem. Cut off from support, women often come to believe these lies, fearing reprisals from their partner if they report the abuse, many choose to tell no one. This long term, relentless, dehumanising process can result in a woman believing that she is ‘disposable’.”

Similarly, the writer and campaigner Sarah Ditum warns that the Bill may not protect

“the patient who, through lengthy cruelty and coercion from a partner or carer, becomes genuinely convinced that she (or sometimes he) is a burden who would be better off dead. Such a person may even refuse treatment, causing a curable disease to become terminal and placing them within the purview of the bill.”

So we might not believe that assisted suicide is in someone's best interests, but there is no best interest test in the Bill or the amendments—just a reference to the person's will. If a victim of coercive control truly believes they ought to die, it is not clear how the doctor or the panel can refuse their application, unless coercion can actually be proved, and proving it is not always easy, as we have just discussed.

My hon. Friend the Member for East Wiltshire has tabled amendments to remove the phrase

“against that other person's will”.

Obviously, that is all academic now, as we are not pressing the amendment to a vote, but I would support doing that, because that phrase does more to narrow the definition than anything else.

On another point, amendments 518 and 520 refer to pressure and coercion from organisations. I do not know exactly what the hon. Member for Penistone and Stocksbridge has in mind with that. I guess an example might be the cases we have heard about in other jurisdictions where a health insurer or provider tells someone that they cannot fund a treatment but can fund assisted dying options. It could be that the hon. Lady had other things in mind there. That would possibly count as pressure under some circumstances, but it would be very hard to show that there was intent on the part of the organisation. It is not clear that the amendments help us to identify and avoid coercion and pressure in that sense.

Before I finish, I would like to point out something else that might be missing from the amendments: it is my favourite topic, the question of undue influence—my apologies to the Justice Minister, because I know we have gone over it a few times.

**Dr Tidball:** Just to put this one to bed, which is where we all need to go at this stage, I did seek advice from those that have worked in this field, and it is not a concept used commonly in the criminal law. It is instead used in the law of equity and would not be as relevant in this context. There were other, sharper elements that could make up this concept of coercion that were better and more well understood in the context of the criminal law.

**Rebecca Paul:** I thank the hon. Lady for that clarification of the information she has been given.

We have gone over the question of undue influence a few times. I promise I will not talk about it for much longer, but it is relevant, which is why I keep raising it. In a judgment that my hon. Friend the Member for Solihull West and Shirley has previously mentioned, Lord Nicholls said that undue influence includes two things. The first is

“overt acts of improper pressure or coercion”.

The second is a kind of influence that

“arises out of a relationship between two persons where one has acquired over another a measure of influence, or ascendancy, of which the ascendant person then takes unfair advantage...The influence one person has over another provides scope for misuse without any specific overt acts of persuasion. The relationship between two individuals may be such that, without more, one of them is disposed to agree a course of action proposed by the other.”

That definition suggests something broader than what is described in amendments 518 and 520, but I take the point that the hon. Member for Penistone and Stocksbridge has just clarified. The amendments suggest that somebody will actively interfere with someone else’s “decision-making autonomy” and have an intention to induce them to do something. But Lord Nicholls’s definition of undue influence is much less dramatic; it just identifies a relationship where one person’s view holds a lot of sway. For the last time—I promise—I would be grateful for the Minister’s view on that. I am sure she will talk through that point and advise on the clarification the hon. Lady has just given.

In conclusion, the amendments are completely well intended. It is helpful that the hon. Lady tabled them and that we have had this debate, and I am grateful to her for that. However, I am inclined to think that they

would narrow the definition too much. My preference would be to remain with what we have, subject to the points I have raised many times on undue influence.

**Dr Tidball:** Does the hon. Member agree that it is helpful to have it on record that we have evaluated these concepts from all sides, but determined that putting them in the Bill is not the right thing to do and would be too restrictive at this point?

**Rebecca Paul:** I would not choose to have this specific definition in the Bill. There may well be another definition that I would be more comfortable with, so I cannot rule that out. However, I completely agree with the hon. Lady that this has been a helpful debate, and I really appreciate her tabling the amendments so that we could have it.

**Sarah Sackman:** Bear with me one moment, Sir Roger. I have just had a message, and I want to see whether it is relevant to what I want to say. Forgive me.

**The Chair:** I think it says, “Keep it brief.”

**Sarah Sackman:** I was just checking that my eyes are not failing me.

It is good to see consensus break out across the Committee on these issues. For what it is worth, both as a Government Minister and a Committee member, I think it is excellent that we have had this debate on definitions. All members of the Committee have an interest in ensuring that where the words “coercion”, “pressure” and “dishonesty”, which run through all the relevant amendments, appear in the Bill—whether in relation to the eligibility criteria or the criminal offences—they operate as intended and with the breadth to capture the range of behaviours they are seeking to safeguard against.

I will be brief because we have rehearsed a number of these issues before. Indeed, my hon. Friend the Member for Penistone and Stocksbridge has stolen my thunder in many respects and said a lot of what I was going to say. In relation to the definitions of coercion, pressure and dishonesty, to which the various amendments relate, it is important to note—and this is the Government’s view—that including a statutory definition would risk overcomplicating the issue and inadvertently narrowing the protections that the criminal offences in the Bill are intended to provide. At the moment, the Bill does not include a statutory definition for any of those terms. As a consequence, they carry their natural meaning, as construed by the courts, and therefore have, in practice, a broad meaning.

9 pm

For example, in the case of *F v. M* of 2021, Mr Justice Hayden stated that the expression “coercive and controlling behaviour”—in the context of section 76 of the Serious Crime Act 2015, where the term “coercive” appears—is not given any legal definition because “it requires none.” That is because the term as applied by the courts is unambiguous, usually involving a pattern of acts encompassing, for example, assault, intimidation, humiliation and threats. Indeed, the wide range of ways in which coercion and pressure can manifest themselves

has been captured by the common law. Examples include isolating a person from friends and family and support networks, and restricting access to a doctor, which might be pertinent in this context. These are the sorts of behaviours that are captured in the common law by the terms under discussion. Because each of those words is given its normal meaning, the terms capture all the types of behaviour that we would expect them to capture—from the subtle to the explicit. That allows the courts the flexibility to consider the broadest range of behaviours, which I understand is also the policy intent of the Bill promoter.

As hon. Members are all well aware, the Government's role is to ensure that the law as decided by Parliament is robust and workable. Our position, in common with that of others, is that adding these definitions would risk having the opposite effect from that intended. We are discussing well-understood terms within our corpus of law, and adding any statutory definitions would risk putting that in doubt in a way that was confusing for the professionals who needed to apply them, and might restrict prosecutorial discretion and narrow the very safeguards that are intended to be provided.

On the specific point raised by the hon. Member for Reigate, I reiterate that the breadth of the range of meanings captured by “coercion” and “pressure” would, in the Government's view, encompass what I think she is concerned about. Undue influence would be caught by those terms in practice.

**Kim Leadbeater:** It is fair to say that we have had a very valuable discussion on the matters relating to these amendments. I thank my hon. Friend the Member for Penistone and Stocksbridge for the considerable amount of hard work that she has put into researching these issues. As always, her approach has been extremely thorough and diligent.

I have been on my own journey regarding the need or otherwise to place definitions in the Bill, but having undertaken the valuable discussions we have had through this Committee—I think this genuinely has been the Committee at its best—along with the expert legal input and advice that my hon. Friend and the Committee have had, I think we are in the right place to enable the courts to ensure that the law is as expansive as possible and to ensure that we do not create a scenario in which certain behaviours from those with mal-intent in relation to the Bill are excluded from its scope. I agree that we should allow the courts to do their job with the broadest possible powers to prosecute offences under the Bill. I echo my hon. Friend's comments to the Minister about the need for the inclusion of details about these issues in guidance and codes of practice, but I thank the Committee for an extremely useful and productive discussion.

**Dr Tidball:** I am grateful for the thorough and thoughtful discussion that we have had from Members on both sides of the Committee Room. I am pleased and reassured that we have that discussion on record, so that those looking at the work that we have done in this Committee will understand the depths and levels at which we have thought about these important concepts in this space and the extent to which we have challenged and checked Ministers in making sure that they understand our concern about these provisions being properly put in

place. I also thank my hon. Friend the Member for Lowestoft for her important input, which I hope will be reflected in the training.

I am glad that we have come this far and that we have a level of unanimity across both sides of the Committee Room. That is a nice point to reach as the Committee comes towards the end of its journey, and it reflects the essence and the intention that were so evident on Second Reading. I beg to ask leave to withdraw the amendment.

*Amendment, by leave, withdrawn.*

**Kim Leadbeater:** I beg to move amendment 392, in clause 40, page 23, line 27, at end insert—

“‘first assessment’ has the same meaning as in section 7;

‘first declaration’ has the same meaning as in section 5;”.

*This is a drafting change.*

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

Amendment 424, in clause 40, page 23, line 37, at end insert—

“‘preliminary discussion’ means a discussion of a kind mentioned in section 4(3);”.

*This is a drafting change.*

Amendment 393, in clause 40, page 24, line 5, at end insert—

“‘second assessment’ has the same meaning as in section 8;

‘second declaration’ has the same meaning as in section 13;”.

*This is a drafting change.*

**Kim Leadbeater:** These amendments are drafting changes, but they are important drafting changes, in that they are about the definitions of first assessment, first declaration, second assessment, second declaration and preliminary discussion. They are small but important changes and I hope that the Committee will support them.

**Stephen Kinnock:** The Government have been working with my hon. Friend the Member for Spen Valley, and some amendments—including all three in this group—have been mutually agreed by her and the Government with the aim of ensuring the workability of the Bill. I shall provide a brief technical, factual explanation and rationale for the amendments.

Amendment 392 would add the meaning of “first assessment” and “first declaration” to the list of definitions in the interpretation provision in clause 40. The effect of the amendment is to ensure that all references to “first assessment” and “first declaration” throughout the Bill are interpreted consistently.

Amendment 393 would insert the meaning of “second assessment” and “second declaration” to the list of definitions in the interpretation provision in clause 40. The effect of the amendment is to ensure that all references to “second assessment” and “second declaration” throughout the Bill are interpreted consistently.

I turn to amendment 424. Clause 4(3) states:

“Where a person indicates to a registered medical practitioner their wish to seek assistance to end their own life in accordance with this Act, the registered medical practitioner may...conduct a preliminary discussion about the requirements that need to be met for such assistance to be provided.”



Clause 4(4), as amended, sets out that where a practitioner conducts a preliminary discussion, they must explain and discuss certain matters with the person concerned. These are:

- “(a) the person’s diagnosis and prognosis;
- (b) any treatment available and the likely effect of it;
- (c) all appropriate palliative, hospice or other care, including symptom management and psychological support”.

The preliminary discussion may not be conducted in isolation from an explanation of and discussion about these matters. Amendment 424 would add a definition of “preliminary discussion” to the list of definitions in clause 40 to ensure that all references to a “preliminary discussion” in the Bill are interpreted in line with the description of the discussion in clause 4(3).

*Amendment 392 agreed to.*

*Amendments made:* 226, in clause 40, page 23, leave out line 37.

*The amendment is consequential on Amendment 545.*

Amendment 424, in clause 40, page 23, line 37, at end insert—

“‘preliminary discussion’ means a discussion of a kind mentioned in section 4(3);”

*This is a drafting change.*

Amendment 393, in clause 40, page 24, line 5, at end insert—

“‘second assessment’ has the same meaning as in section 8;

“‘second declaration’ has the same meaning as in section 13;”.—(*Kim Leadbeater.*)

*This is a drafting change.*

**Danny Kruger:** I beg to move amendment 527, in clause 40, page 24, line 14, at end insert

“provided that such remuneration is not structured in a manner where it would be greater as a result of the registered medical practitioner approving the request.”

This is the point at which the season of consensus is over; I am back to opposing. Amendment 527 would insist that any remuneration for taking part in assisted dying on behalf of the medical profession would not enable a system whereby a medic, practice or private provider would be remunerated according to approving the different stages of the process. I am trying to prevent the provision of any incentive in the system for moving people through it.

We know that there can be a paid private service delivered under the Bill. The concern is that we will create perverse incentives in the system that will prejudice objective decision making. I take the points about the disinterested good faith of all medics; nevertheless, I do not want to put them in danger of feeling the pressure of perverse incentives. We must recognise the importance of keeping absolute financial neutrality in the operation of the Bill. There would be significant ethical red flags about a system that essentially enabled performance-related pay tied to approving requests for assisted dying, let alone paying doctors to provide referrals to a co-ordinating doctor. At the moment, I do not see that the Bill prevents that.

Even if there were no such danger, I am not sure that patients would buy it. From the point of view of trust in the medical profession, we must bear in mind that any doctor could be involved. Any doctor could either raise the suggestion or be required to signpost a patient who

raised it themselves—the whole of the NHS is essentially implicated in the proposed system. As the hon. Member for Spen Valley has reiterated today, she wants assisted dying to be an integral part of the NHS. Let us protect the NHS from the distrust of patients by ensuring that financial incentives are not in the mix for these life and death decisions.

**Dr Opher:** Although I see the hon. Gentleman’s ideas and points, what will be paid for here is the assessment. I know no medical process where the outcome is paid for, rather than the assessment. Although I can see that his concerns are real, I do not believe—

**Danny Kruger:** I am sorry to cut off the hon. Gentleman mid-flow, but he says he cannot think of an instance when the outcome will be paid for. It would perhaps not be about paying for the outcome—paying for death; for a dead body—but there could well be payments for the process leading up to that. That is the way medical payments work at the moment. Someone might get paid for the assessment, the second assessment, or the administration of the drugs. People do get paid in the NHS for delivering a treatment. Why would that not be the case here?

**Dr Opher:** I understand the hon. Gentleman’s concern, but that is just not the way that medicine works. The doctor is under a code of practice, so if he is seen to lie about assessment of capacity or coercion, for example, to enable him to approve the decision and then go on to assist the dying, he would be well outside that code. He would be referred to the General Medical Council and, in such a case, struck off the medical register. I understand the reason for the amendment moved by the hon. Gentleman, but I do not feel that it is necessary in this part of the primary legislation.

9.15 pm

**Lewis Atkinson:** I understand somewhat where the hon. Member for East Wiltshire is coming from, but as a fundamental matter, people have to be paid for time worked. I feel that an interpretation of his amendment is that people would not be able to be paid for time worked. This is not about performance-related pay, as he suggests in that continuation of his—I suggest—scaremongering theme from before, but about remuneration for time worked. For example, if someone is referred for an additional capacity assessment, it is right that the person doing the assessment is paid for their time worked, not as an incentive, but as a normal payment for time worked. I think that the amendment is poorly drafted and not workable. I will therefore vote no.

**Stephen Kinnock:** The amendment is linked to clauses 5 and 8, which define who can and cannot be a co-ordinating or independent doctor. According to the clauses, a person who benefits financially from the death of the person cannot be a co-ordinating or independent doctor. As the Bill stands, clause 40(4) provides that a registered medical practitioner is not to be regarded as benefiting financially, or in any other material way, from the death of a person by reason only of the practitioner receiving reasonable remuneration for the provision of services in accordance with the Bill.

[Stephen Kinnock]

The amendment may broaden what is meant by “benefiting financially”, so that its effect may be to prohibit a person from being a co-ordinating or independent doctor if their remuneration is greater for applications that are accepted than for ones that are rejected. However, as drafted, it is not possible to determine the effect of the amendment with certainty, so further amending is likely to be required at a later stage should the Committee accept the amendment.

**Kim Leadbeater:** I will not test the patience of the Committee by repeating the comments of my hon. Friends the Members for Sunderland Central and for Stroud and, indeed, of the Minister. I am comfortable that subsection (4) as it stands is perfectly acceptable on the remuneration that a doctor can receive. I will not support the amendment.

**Danny Kruger:** I must conclude from that that the promoter of the Bill, the hon. Member for Spen Valley, and the Minister would be content with an arrangement whereby a doctor was paid more for accepting an application and processing it, and for referring a patient—

**Kim Leadbeater:** Will the hon. Member give way?

**Danny Kruger:** Suddenly the debate is occurring. I am happy to give way.

**Kim Leadbeater:** That absolutely is not what we have said.

**Danny Kruger:** In opposing my amendment, the hon. Member is declaring herself content with the text of the clause as it is. The text as drafted would allow a doctor to be paid more, the more applications that they receive, process and refer on. That might not be, in her mind, how the system should work—I would be grateful to know how the system should work, because it is not in the Bill or in the amendments. We have a very vague arrangement here, whereby a private provider would be enabled to deliver assisted dying—indeed, a profit-making organisation would be able to manage the entire process from beginning to end, even referring a second assessment to another part of their own company.

**Kim Leadbeater:** Will the hon. Member give way?

**Danny Kruger:** In a moment. The potential—as would happen in other parts of genuine healthcare—is that the more work people do, the more money they get. My concern is that that induces a dangerous incentive into the system. Having a global fee paid to a provider who managed the service would be much safer. The crucial point is that we prevent people being paid for approving and enabling assisted deaths, and that is what my amendment would do.

**Jake Richards:** I appreciate the point that the hon. Member is trying to make and I think it is a fair one, but how does he think this could work? As he said in his own intervention, people might have to be paid for one part of the process, and then for the next. If we appreciate

the principle that people get paid for time, there is inevitably more money involved as the process goes on, so can he explain how his amendment would work?

**Danny Kruger:** I intend, in a later debate when we come to the new clause, to try to explain how I think we should have done this. The answer to the hon. Gentleman’s question is that an organisation should be resourced—I think through philanthropy, rather than taxpayers’ money or people paying out of their own pocket, but the point stands however we do it—to deliver the assisted dying service, but crucially it should not be paid more per service, treatment or customer. We should not have the concept of customers in this arrangement; there should be a provider who is resourced to deliver this service. The crucial point is that they should not be paid more per client or for progressing people through the system.

**Naz Shah:** That is the exact point I was about to raise. Is another amendment needed to ensure that providers of this service are not given more money if a patient goes through the process than if the process is stopped?

**Danny Kruger:** That is the purpose of my amendment.

**Kim Leadbeater:** The hon. Member is making some interesting points, but they are not related to the point of this amendment, which talks about the doctor being given more money for approving the request. That is not quite the same point that he is making.

**Danny Kruger:** I imagine that a doctor who works for the non-profit service I am envisioning would be paid a salary and do their work, but would not be paid on a per-client basis—they would not be paid a tariff for the number of people they passed through the system, let alone for the different chunks of the process. People need to be paid, but they should not be paid on a per-client basis, because that would introduce dangerous incentives into the system.

**Lewis Atkinson:** The hon. Member is making an interesting point, particularly in relation to the commissioning of the service. In the NHS, we generally commission on a block basis and a fee-per-activity basis. I can entirely see that that block basis would be appropriate for this commission, and I am happy to work with him on Report to make that the case. That is not what this amendment says, though. It talks about payment for individual doctors, which gets into the issue of people being fairly paid for their time, which he referenced. I invite him to collaborate on the commissioning arrangements on Report, rather than pressing this amendment.

**Danny Kruger:** We can distinguish between the organisational income and the specific doctor’s income, but the same applies in both cases. Explicitly, the doctor who is making the decisions should not feel the pressure or the temptation of financial reward to expedite or approve applications for assisted dying. I am grateful for the hon. Gentleman’s invitation. By all means, let us try to make sure that, should the Bill reach Report stage, we remove the danger of perverse incentives in the way that the service is commissioned.

*Question put, That the amendment be made.*

*The Committee divided: Ayes 8, Noes 15.*

**Division No. 78]****AYES**

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

**NOES**

Abbott, Jack	Malthouse, rh Kit
Atkinson, Lewis	Opher, Dr Simon
Charalambous, Bambos	Richards, Jake
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 negated.*

*Clause 40, as amended, ordered to stand part of the Bill.*

*Clause 41 ordered to stand part of the Bill.*

**Clause 42****COMMENCEMENT**

*Amendment made: 546, in clause 42, page 24, line 18, after “Sections” insert*

*“(Reporting on implementation of Act),”—(Kim Leadbeater.)*

*This amendment is consequential on NC40.*

**Kim Leadbeater** (Spenn Valley) (Lab): I beg to move amendment 547, in clause 42, page 24, line 19, at end insert—

“(1A) Section (Voluntary Assisted Dying Commissioner), except subsection (4) of that section, and Schedule (The Voluntary Assisted Dying Commissioner) come into force at the end of the period of one year beginning with the day on which this Act is passed.”

*This amendment provides that the clause and Schedule relating to the Commissioner, except subsection (4) of the clause, come into force one year after Royal Assent.*

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

Amendment 531, in clause 42, page 24, line 21, at end insert—

“(2A) The Secretary of State may not make a statutory instrument containing (whether alone or with other provision) regulations under subsection (2) bringing sections 1 or 24 into force unless they have previously laid before Parliament a report containing an analysis of—

- the readiness of services to provide assistance and related functions of this Act, and
- training that has been provided under the provisions of this Act.”

Amendment 488, in clause 42, page 24, line 22, 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 which bring section 18 into force unless the condition in subsection (3A) is met.

(3A) The condition is that a Minister of the Crown has made a statement to each House of Parliament that sets out—

- that, in their opinion, all regulations necessary for the effective provision of assistance have been made under this Act; and
- a list of the regulations that have been made for the purposes of paragraph (a).”

*This amendment would prevent the Minister from making a commencement order for section 18 without a statement first being made to each House of Parliament stating that all necessary regulations for provision of assistance have been made and setting out what those regulations are.*

Amendment 489, in clause 42, page 24, line 22, leave out subsection (3).

*This amendment would remove the automatic coming into force of provisions under the Act two years after it is passed.*

Amendment 548, in clause 42, page 24, line 23, leave out “2” and insert “4”.

*This amendment provides that any provision of the Bill not brought fully into force before the end of the period of 4 years beginning with the day on which the Bill is passed will come into force at the end of that period.*

Amendment 536, in clause 42, page 24, line 23, leave out “2” and insert “5”.

*This amendment would increase the time period given between the passing of the Act and the automatic coming into force of provisions under the Act to five years.*

Amendment 535, in clause 42, page 24, line 25, at end insert—

“(3A) Subsections (2) and (3) do not apply in relation to Wales.

(3B) In relation to Wales, the provisions of this Act not brought into force by subsection (1) come into force on such day or days as the Welsh Ministers may by regulations appoint (and such regulations may not be made unless a draft of the statutory instrument containing them has been laid before, and approved by a resolution of, Senedd Cymru).”

Amendment 490, in clause 42, page 24, line 30, at end insert—

“(7) The Secretary of State may not make a statutory instrument containing (whether alone or with other provision) regulations under subsection (2) unless a draft of the instrument has been laid before, and approved by a resolution of, each House of Parliament.

(8) The Secretary of State may not lay a draft of an instrument under subsection (7) unless they have already laid before each House of Parliament a report providing an analysis of the expected efficacy of services and functions performed under this Act.

(9) The report under subsection (8) must, in particular, set out—

- the extent to which the Act is expected to meet its aim of allowing adults who are terminally ill, subject to safeguards and protections, to request and be provided with assistance to end their own lives;
- an assessment of the availability, quality and distribution of appropriate health services to persons with palliative care needs, including—
  - pain and symptom management;
  - psychological support for those persons and their families;
  - information about palliative care and how to access it;
- any concerns with the operation of this Act which have been raised; and
- the Secretary of State’s response to any such concerns and planned actions to be taken in response to those concerns.”

*This amendment would change the procedure for commencement orders to the affirmative procedure and require a report to have been laid providing an analysis of the likely impact of the Act.*

Clause stand part.

Clause 43 stand part.

**Kim Leadbeater:** Amendment 548 is not one that I had hoped to table, but I recognise that it is necessary. It is important to be clear about what it says and what it does not say. It creates a four-year backstop, meaning that the provisions of the Act must be implemented within four years of Royal Assent. What it does not say is that it cannot be implemented sooner than that, and I hope and believe that it can. A backstop is not a deadline.

Hon. Members who have been in this House longer than I have will be very familiar with the idea of a backstop. In this, as in previous contexts, it is not intended as the desired outcome but a form of protection. The Bill as originally drafted stated that, if all its provisions had not been brought fully into force after two years, they would come into force at the end of that period. Under the amendment, that period would now be four years.

I cannot pretend that I am not disappointed about extending the commencement period, and I know I am not alone. When I started work on the Bill, I thought, “Gosh, two years to implement it. That is a long time to leave the law uncorrected. How many terminally ill people will face the trauma and expense of travelling to Switzerland or feel they have no alternative but to take their own life or suffer a deeply traumatic death as a result of their illness in that time? How many more families will face the possibility of a police investigation, or have the happy memories of their loved ones tainted by their final weeks or days, due to the impact of their terminal illness?” That sat very heavily with me.

But I thought then, and still think now, that however difficult it feels at times, this is not a process that should be rushed. It is more important to do this properly than to do it quickly. I am pleased that the Committee has improved the Bill in many ways, and added extra safeguards to what was already the strongest assisted dying legislation in the world—in particular, with the setting up of a new judge-led voluntary assisted dying commission, with multidisciplinary panels to look at every application. Inevitably this will take longer to implement than simply referring cases to the High Court, an institution that already exists.

The reporting and monitoring mechanisms and infrastructure, along with the comprehensive training programme that we have rightly discussed at length in Committee, will take time to put together. It is clearly important to dedicate the necessary time to implementing these safeguards, but I also know the upset and disappointment that many people will feel about a potentially longer commencement period, so it is with some reluctance that I ask the Committee to support the amendment.

As I have said, four years is very much a backstop, not a target. If the Bill receives Royal Assent, I for one—I know that I will not be alone—will hold the Government’s feet to the fire to ensure that its provisions are put in place as quickly as is practicable and safe to do so. To that end, amendment 547 would ensure that the voluntary assisted dying commissioner will be appointed within 12 months of the Bill passing. New clause 40, as previously debated, would confer a duty on the Secretary of State to report to Parliament at that 12-month point, and every six months thereafter, until it has been fully implemented. Those are important steps to show progress and to demonstrate accountability and transparency.

At lunchtime today I met a group of people—many terminally ill themselves—representing thousands of others who are looking to this Parliament to finally offer them or their loved ones the choice and dignity of a better death. I know, because they have told me, that they are disappointed by this change. I said to them that I would not be making it if I had not been persuaded that it was necessary, but I also said that I will do everything I can to not keep them waiting a moment longer than we absolutely have to. I hope that the Committee can support the amendments.

9.30 pm

**Sarah Olney:** I rise to speak to my amendments 531 and 535 and to amendment 490 in the name of my constituency neighbour, my hon. Friend the Member for Twickenham (Munira Wilson).

I welcome what the hon. Member for Spen Valley has just said about needing more time to get this right. As I said earlier, there is still so much that has been left to secondary legislation. I regard that as unsatisfactory in itself, but the fact that we are going to take time to get it right will surely go some way to mitigating some concerns.

I have heard raised around the estate on a number of occasions today the concern that the four-year gap between passing the legislation and implementing it will take us right up to the next general election. I have to say that I share those reservations, even though I am not a member of the party of government, about how the general election campaign will intersect with the implementation of this legislation. I share people’s fears that this whole process will get enmeshed in party politics, which we have hitherto been able to avoid in the Committee, but nevertheless could create a real danger for successful implementation.

I did think that the auto-commencement of this Bill after two years was a little bit reckless. The extension to four years at least permits some potential improvement in palliative care—to re-ignite the spirit of consensus, as that is something that we all want to see—but an NHS already grappling with long waiting lists and staffing shortages could buckle under the added burden of implementing a complex new framework leading to rushed or inconsistent application. An automatic commencement of the new laws, regardless of the situation in the NHS, could leave patients and healthcare workers unsupported.

It is important is that, before the moment comes—whenever that is—Parliament should be fully informed as to how the service will be provided and the strength of other provisions, so that MPs can be confident that those choosing to end their lives through this service are given a fair choice and are not being pushed down a single pathway. We must also have confidence that the medical professionals and panels involved have received adequate training.

Amendment 531 would ensure that at least we go into this with our eyes open and that shortcomings are flagged if not addressed. It would provide that the critical provisions of the Bill, without which assisted dying cannot lawfully operate, do not come into force until a report is made setting out the readiness of services to be provided under the legislation and that the training has been provided. Similarly, amendment 488, in the name of the hon. Member for York Central, mandates

a statement from both Houses that all necessary regulations are in place. This would prevent a premature roll-out without clear rules. These steps would not halt progress; they would ensure we are ready to proceed.

Amendment 490, in the name of my hon. Friend the Member for Twickenham, does two important things. First, it requires that if the Secretary of State wants to commence before the auto-commencement deadline, they must publish a report covering the same matters covered by the report under clause 35. This would not be a new requirement, but would instead bring it forward. Crucially, that report would include details about the provision and availability of palliative care services in England and Wales.

Secondly, amendment 490—this is it goes further than my amendment 531 and amendment 488—requires that regulations bringing the Act into force prior to the auto-commencement deadline use the affirmative procedure: in other words, that there will be a vote in Parliament. It stands to reason that if the Secretary of State wants to go quicker than the four-year deadline, then Parliament ought to be able to consider whether all necessary preparations have been done and to refuse early commencement if that is not the case.

Amendments 488, 490 and 531 would not interfere with the auto-commencement point in four years' time: when four years is reached the whole scheme will come into force. Those amendments would not prevent that, but they would achieve greater oversight and accountability if the Secretary of State decided to commence early. I hope that even if the hon. Member for Spenn Valley is not minded to accept striking out the auto-commencement provisions, she will still accept these amendments.

**Kim Leadbeater:** The hon. Member makes some very fair points, but I think they will be covered by my new clause 40.

**Sarah Olney:** I am grateful for that intervention, but the crucial point is the vote in Parliament, so that MPs get not only an opportunity to consider whether sufficient progress has been made—as per new clause 40—but a vote to confirm that they are content for the legislation to proceed.

**Kit Malthouse:** I am sure the hon. Lady understands that a vote of that nature would not necessarily be binding, or compel the Government to do anything, but there would be other opportunities for the House to consider the legislation in debate and vote on it. She knows that there are a number of ways to do that, including via a Backbench motion or an Opposition day.

**Sarah Olney:** I refer to my earlier comments: there are few enough opportunities for MPs to have any further control over how this legislation is going to be implemented. I do not think that it is asking too much to want a further opportunity to be mandated, and not left—dare I say it—to the vagaries of the Backbench Business Committee. There are Opposition days, but this is cross-party, conscience issue. I can speak only for my own party, but I think there are a number of other issues that the Opposition would want to use those debates to address. Taken together, these amendments

would ensure that Parliament is properly informed if the Secretary of State decided to commence the scheme before the four-year auto-commencement deadline.

I want to address how the Bill will be implemented in Wales. On 23 October 2024, in anticipation of the Bill being published, Senedd Cymru debated a motion calling on the Welsh Government to

“a) support the principles of assisted dying; and

b) support Westminster parliament to introduce a compassionate assisted dying law in England and Wales.”

The motion was defeated 19 to 26. Among those who voted against were a number of Welsh Government Ministers, including First Minister Eluned Morgan, and I believe that in three political parties—Labour, Plaid and the Conservatives—there was a majority against. In that context—as Professor Emyr Lewis, who gave evidence to the Committee, has stated—it would be constitutionally wrong to pass the Bill without the consent of the Welsh Senedd. He believes that this is different from other instances where legislation has been passed by Westminster against the will of Wales:

“This is not the equivalent, for instance, of trying to re-base the UK's internal markets following the chaos of Brexit. When the UK Parliament passed Acts ignoring refusal of consent from Cardiff or Edinburgh, it did so in what were considered to be the interests of the economic coherence of the UK. This Bill, however, is a different sort of creature. It is a Bill which would bring about a profound change in the law relating to life and death, where there are strongly held (and expressed) moral, religious and cultural views against as well as in favour. How can it be constitutionally appropriate for the UK Parliament to pass such a Bill for Wales, when the Senedd has indicated its opposition by democratic vote after a thorough debate?”

**Kim Leadbeater:** I hope the hon. Member can acknowledge that the motion voted on in the Senedd was very different from the legislation before this Parliament. I hope that I can reassure her, as I have previously, that I am in contact with the Senedd and will be meeting Welsh Ministers. New clause 37 will hopefully also provide some reassurance on issues around devolution.

**Sarah Olney:** I again refer to what I said earlier: I fear this is another example where, instead of debating and agreeing these points in Committee or elsewhere in Parliament, we are delegating these matters to be decided elsewhere by some other people, not in the legislation that we are debating and voting on.

I reiterate that the Senedd has already made its view clear. It may not have been a binding vote. It may not have been voting on this specific piece of legislation. However, I think the will of the Senedd is clear: they do not want an assisted dying Bill imposed upon them, and that is what the evidence of Professor Emyr Lewis told us.

**Kim Leadbeater:** I think that is a very inaccurate representation of the vote that took place in the Senedd.

**Sarah Olney:** I am sorry that the hon. Lady feels that.

The complicating factor here is that the criminal law is not devolved to Wales, but health is, as is safeguarding. One possibility is to seek to respect devolution strictly, by either changing the law or giving the power to the Secretary of State to change the law in respect of what is reserved, while giving to the Welsh Ministers the

[Sarah Olney]

powers in respect of what is devolved. The problem is that the Bill does not quite do that, even with the amendments that have been tabled by the hon. Member for Spen Valley. Those amendments fail to properly identify what is and what is not devolved; instead, they kick the can down the road.

Future litigation might be required to figure out the precise boundaries. For example, regulation of health professionals is a reserved matter, but adult safeguarding is a devolved matter, so is the training of those health professionals on spotting coercive control a reserved or a devolved matter? The Bill does not answer that question. The solution therefore carries a real risk. If Wales decides that it does not want assisted dying and therefore does not provide it on its NHS, and the Welsh Ministers decide not to set up proper training and regulatory programmes in respect of the safeguarding issues raised, the position in Wales will be that it is decriminalised, so the service can be provided by private providers charging a fee and not necessarily properly trained in safeguarding. That is not a sustainable middle ground, so it would naturally pressure Wales to move towards commissioning such services itself.

In other words, the Bill either respects devolution at the risk of creating a legal limbo, or it puts pressure on Wales to catch up with England, neither of which are desirable. Another alternative is to take away any choice that Wales might have on the matter entirely, and have the law apply in Wales in exactly the same way it does in England, including when it comes to the actual delivery of services. That would avoid the legal limbo problem, but at the cost of acting in a way that is constitutionally quite wrong.

That brings us to the solution that Professor Lewis proposed in his blog:

“How then might the Bill be amended to respect the Senedd’s vote on the matter of principle? One straightforward way would be to provide for different commencement provisions in the Bill. As things stand, under clause 42 of the Bill, most of the Bill will not come into force until the Secretary of State has brought it into force, with the approval of the UK Parliament. Why not provide that the Bill will only come into force in Wales when and if the Welsh Ministers bring it into force with the approval of the Senedd?”

That is what I seek to do through my amendment.

I can foresee three objections. First, it might be said that the criminal law is a reserved matter and therefore Parliament ought not to refrain from legislating for Wales or have different commencement arrangements for the criminal law in England compared with Wales, but Parliament is sovereign and can do what it wants. By the same reasoning, Parliament should never grant a temporary power to a devolved legislature to legislate on matters that are normally reserved, yet Parliament does do that.

The second objection might be that England and Wales are a single jurisdiction, and that there should not be a difference in the criminal law between them, but this misunderstands that, as a result of the devolution settlement, there are already differences in the criminal law of England and Wales. For example, in our law there is a defence of reasonable chastisement, which means that parents smacking their children would not be committing a criminal offence. Although the criminal

law is not devolved to Wales, child welfare is and, using those powers on child welfare, the Senedd voted to abolish the defence of reasonable chastisement in Wales. That means that there is a difference in the criminal law of England and Wales. A position whereby assisting suicide was partially decriminalised in England but fully criminalised in Wales would not be an oddity. There is no principle of our constitution that says that the criminal law must be the same on both sides of the border.

The key issue is that the decriminalisation of assisted suicide, which the Bill will bring about, is not a stand-alone measure. What we are introducing is not something like the Swiss criminal code, for example, which does not criminalise assisted suicide when the person acted for non-selfish motives. Rather, it is a decriminalisation of assisted suicide that is contingent with complying with a detailed healthcare regulatory scheme, which is an issue that is devolved to Wales.

Finally, it might be objected that this might create difficult cross-border issues. As Professor Lewis put it in his blog,

“that would be true also if, for instance, the Scottish Bill did not become law. Far more difficult cross-border issues were successfully accommodated in the context of legislation, also involving profound ethical considerations, when the National Assembly for Wales (as the Senedd was then called) changed the law on organ donations.”

I accept that such a situation might require constitutional amendments at subsequent stages, but these could easily be made by the Government on Report.

Ultimately, when one looks at it in detail, having a different commencement provision for Wales is the only practical way of respecting the vote of the Senedd while not running the risk of creating a legal limbo. Finally, I draw the Committee’s attention to the supplementary written evidence of Professor Lewis, in which he commends my amendment 535.

Regardless of where we stand on assisted dying, we should respect democracy. The people of Wales, through their elected representatives—acting as they should, as representatives—have voted against assisted dying. We should respect that choice and not impose it on them, in whole or in part, without their consent.

9.45 pm

**Jake Richards:** I rise to speak briefly in support of amendment 548, tabled by my hon. Friend the Member for Spen Valley. I do so fundamentally for two reasons.

First, there may be a lot of support for the principle of assisted dying among members of the Committee and, indeed, Members of the House, but there are also understandable concerns about its implementation. We have been debating all the aspects of that over a lengthy period in Committee, and it is undoubtedly complex. Although my hon. Friend is disappointed that she has had to table the amendment, I commend her for doing so, because it is important to get this right and to be brave by setting longer time limits if necessary. I think that can be reassuring to Members who, while supporting the principle, want to make sure that we get this right. I hope that the amendment will do that.

Secondly, for those people—including those who have been in the Public Gallery today, Committee members and, indeed, other Members of the House—who might be disappointed about the delay, in my mind the amendment is not an obstacle to change. In fact, what we have seen

here is the Bill's promoter working with the Government, who remain neutral on the principle but want to make the Bill deliverable, to come up with a sensible, pragmatic proposal for how and at what speed this profound change is to be implemented. In my mind, that gives a sense of the Executive and the promoter thinking about the practicalities.

I urge those who are desperately seeking this change and have fought for decades to secure it to approach this measure with a sense of optimism. This is serious. This is a once-in-a-generation opportunity to deliver that change. I hope that, both in the Committee and outside it, they will support my hon. Friend the Member for Spen Valley, who has gone to great lengths to build support and to make sure that the Bill is workable. I will be voting for amendment 548 with a great sense of reassurance, but also a great sense of optimism that one day this country will see this change, which is so desperately needed.

**Liz Saville Roberts:** I rise to support amendment 535. I do not intend to say much, because the hon. Member for Richmond Park has made many of the points I wished to make. The amendment recognises that an opinion was stated in a debate in the Senedd in October, which dealt in detail with the principles of this Bill, and that Professor Emyr Lewis told us that one way of recognising that would be to consider different commencement provisions in Wales.

Reference has been made to the different criminal law arrangements in England and Wales to do with smacking children, and during covid there were quite definitely different arrangements between England and Wales. After a quarter of a century of devolution, we have devolution divergence, and we are seeing that in action.

We have already accepted the principle that there are aspects of the Bill that are devolved, responsibility for which must be passed to Welsh Ministers. We are still debating the wording of that, but we are working towards it, and I think we have accepted the principle of it. We should also acknowledge that the Senedd and Welsh Ministers may well be able to make a move that would have the same effect of changing the commencement date, but I support the amendment because it shows that we are acknowledging the consequences and implications of a legislative consent motion. Incidentally, I could often stand up here and talk about the fact that legislative consent motions can be overridden by Westminster, but we are working from the point of view of seeking to respect devolved powers alongside the powers that we have here, so I will be supporting amendment 535.

**Tom Gordon (Harrogate and Knaresborough) (LD):** It is an honour to serve under your chairmanship, Sir Roger. I rise regretfully to speak in opposition to amendment 548, which would extend the implementation period from two to four years. I start by saying that I have had complete and utter admiration for the hon. Member for Spen Valley throughout this process, and I appreciate that she said herself that she had tabled the amendment in disappointment—I will echo a lot of what she said.

We are here today because we acknowledge that there is an injustice—that the current law for assisted dying is failing people. It forces people who are terminally ill and in unbearable pain to make impossible choices; it

compels them to travel overseas, away from the comfort of home, to die in unfamiliar surroundings; it punishes grieving families by forcing them to endure police investigations for simply standing by their loved ones; and it denies dignity in death and peace in grief. We have recognised that as unacceptable, and that is why we are here debating the Bill.

The delay brought about by the amendment would tell those same people that they must wait. People have already been waiting far too long. The amendment would tell them that their suffering is not seen as important enough and that their right to a peaceful death has to be postponed. It is not justice, and we must not allow it. We know that the British public overwhelming support a change in the law. People want to see assisted dying laws in place during this Parliament, not in some uncertain future. They will not accept delay, and I do not think they will be particularly forgiving of excuses.

If we allow the implementation period to be extended to four years, we will be seen to be kicking the can down the road. Comments have been made about how the implementation would potentially be before the next general election, but there is no guarantee or certainty of that. It is in the gift of the Prime Minister to decide when the next general election is called. I cannot think of a more worrying instance of a newly elected Government having to implement a big societal change, but the amendment could make that a possibility. No Parliament can bind the next, and legislation that has been passed but not enacted could be quickly abandoned. We cannot allow that to happen; the cost would be too great. For people out there who have been campaigning for years, that would be a catastrophe. This is not an abstract policy debate; it is about real people who are suffering right now and cannot afford to wait.

A number of people have been in touch to make clear their views on the amendment. Tim Wardle, a terminally ill man from Devon with bladder, prostate and lung cancer, said that “even a slight delay beyond the two years currently proposed is not fair or reasonable. I hope the proposal is defeated.” Clare Turner, a mother of two with stage 4 breast cancer, made it even clearer, saying, “This is outrageous for terminally ill people like me. Every delay means more suffering, more people forced to endure unbearable pain against their will. This Government needs to stop dragging its feet and act now.” I appreciate that it is not the Government who are promoting the Bill, but that is the reality for people and, as uncomfortable as it is to hear those stories, we must hear them and we must listen.

It is not just people who are terminally ill who are anxious about a change in the law. Every time that I have spoken to my mum on the phone during this Committee process, she has asked me how it is going, what the process is and what the end date will be. It popped up on Facebook yesterday that it is eight years since she received her all-clear from breast cancer, but it still hangs over her. When she was diagnosed, she had two independent tumours, and her mum and her sister—my gran and my aunt—had both had breast cancer too. While there was no genetic testing to show a link, the doctor said, “This is probably going to come back, and you will probably end up with breast cancer again.”

My mum had post-traumatic stress disorder from that experience of going through cancer treatment—through the mastectomy and the recovery. It was prolonged and,

[Tom Gordon]

to this day, there are complications as a result of the procedure and the chemotherapy. It was traumatic for the entire family, and my mum has long said that, if she had to go through something like that again, or if she ended up with secondary breast cancer at a later date, she would want this option. Every time I have spoken to her, she has been really heartened to hear the progress that the Committee has been making on the Bill, and when we spoke about this delay, it crushed her heart—and it has mine, too. Just having the option would give her—someone who does not have a terminal diagnosis or anything, necessarily, just yet—peace and comfort.

Supporters of amendment 548 will say that we need four years to get this right, but I want to know where the evidence for that claim is. It has not been clearly set out. Other countries have managed to implement similar laws in far less time. Spain implemented its law in just three months after the passage of a Bill; Jersey and the Isle of Man are aiming for an 18-month implementation period. Indeed, no country has taken longer than two years. The only example of a particularly protracted and prolonged process was in Oregon, and that was because of legal challenges.

The NHS has demonstrated time and again, particularly during covid, that when there is a need, it can act swiftly and decisively. When we set a deadline, civil servants will work towards it. We have some of the best civil servants in the world, and I commend them for their work. Throughout this process, we have examined the Bill line by line to ensure that it is the strongest, most robust assisted dying legislation in the world. We have strengthened its safeguards and refined the eligibility criteria, although I appreciate that I have had different views from some on the Committee about that. We have embedded rigorous oversight mechanisms and ensured that every step is guided by medical expertise. We have drawn from the best of international practices. We have learned from the experience of jurisdictions that have successfully implemented assisted dying laws with compassion and care.

The Bill is not a rushed or reckless piece of legislation; it is carefully crafted, and it balances the right to choose with the need for stringent protections. To delay its implementation from two years to four years, after such thorough debate, scrutiny and refinement, would undermine the very care and diligence that the Bill has been shaped by. Delaying implementation is not simply a neutral decision; it is a decision to prolong the lack of choice for people with terminal illnesses. It is a decision to deny them the ability to die on their own terms. It is a decision to force more families into impossible situations—watching their loved ones suffer, facing investigations for simply accompanying them abroad, being unable to grieve properly because they cannot even bring the body home. That is the reality of such a delay, and we have the power to stop it.

We cannot allow interference from Government, or wherever this has come from, at the last moment. This is my frustration: the amendment was tabled at the very last moment, without an explanation of where it has come from. We must listen to the people who are at the heart of the Bill. We must listen to the public and all the people who have given us input, to make sure that we end up with a Bill that takes into account the need for

compassion and does not prolong the timetable for people. It is therefore with regret that I will vote against amendment 548.

**Several hon. Members** *rose*—

**The Chair:** Order. I had indicated that I would suspend the sitting at 10 pm, but in the interest of continuity, I propose that we should conclude debate on this clause and then suspend for 15 minutes.

**Dr Opher:** I will be very brief. This is the most difficult speech I have had to make in the Committee. I think all of us who support the Bill are disappointed; I am sure that my hon. Friend the Member for Spen Valley is incredibly disappointed. I believe that the Bill is deliverable within two years, but I have wanted this legislation for about 25 years, and my main aim is that the Bill passes. I understand, from certain dialogues I have had, that that is more likely if we accept amendment 548. In short, therefore, I will support the amendment. I will do so reluctantly, but it has my full support and I will vote for it.

**Naz Shah:** May I thank the hon. Member for Harrogate and Knaresborough for sharing something so deeply personal? I am sure I speak on behalf of the whole Committee in wishing his mum well and hoping that she never has that diagnosis.

I rise to speak to amendments 489 and 488. Amendment 489, tabled by my hon. Friend the Member for York Central, would prevent the Bill's provisions from coming into effect automatically after a certain period had elapsed. The Bill in its original form includes a measure to that effect, in clause 42(3):

“But if any provision of this Act has not been fully brought into force before the end of the period of 2 years beginning with the day on which this Act is passed, that provision (so far as not already in force) comes into force at the end of that period.”

10 pm

My hon. Friend the Member for Spen Valley has now tabled amendment 548, which would change the period to four years, rather than two years, after the Act is passed. After that time has elapsed, any provision of the Bill not fully brought into force would come into force automatically. I believe that two years is far too short a period, so I welcome my hon. Friend's decision to extend it to four years. Under her amendment, however, all provisions of the Bill not in operation would still automatically come into force after a certain period, regardless of whether we are sure that they can be safely implemented.

Such a measure seems to me to have some risk, even if the period has been increased. If we implement assisted dying in this country, we have to get it right as far as possible. Mistakes will mean that the state has wrongly provided people with lethal drugs to end their life. That is not something that we should be prepared to tolerate. Amendment 489 would prevent that by removing clause 42(3).

Amendment 488, also tabled by my hon. Friend the Member for York Central, would take a different approach to bringing all the Bill's provisions into force. It would replace the current wording of clause 42(3) with a new



subsection concentrating on how the Secretary of State would make regulations to bring clause 18 into effect. As hon. Members will know, it is clause 18 that governs the provision of assistance in the part of the process in which the person who is authorised to do so actually self-administers lethal drugs. Under amendment 488, the Secretary of State could make statutory instruments putting that part of the process into effect only after satisfying the condition that a Minister in each House of Parliament has made a statement setting out

“that, in their opinion, all regulations necessary for the effective provision of assistance have been made under this Act”.

They would also have to list those regulations.

That approach is better in several ways. It would mean that Ministers can bring the administration of lethal drugs into operation only when they can demonstrate to Parliament that the right framework is in place for doing so effectively. It would also give Members of this House and of the other place a chance to question Ministers and inquire whether the system really is ready. That is what regulators call a conditions-based approach; it is surely a far better way of ensuring that the system can work than imposing a timeline on Ministers that asks no questions about readiness.

I anticipate that hon. Members may say that this approach will excessively slow down the process of bringing the Bill into effect. However, amendment 548 also slows down the process, such that it will potentially come into full effect only four years after the Act is passed.

Hon. Members may also say that this approach is too cautious. However, every day of our life we expect different levels of caution in different services and operations. We expect anyone who drives on our roads to be trained to a sufficient level to have a driving licence or to be supervised by an instructor, and we expect drivers to carry out basic checks in the mirrors and on the road before they start the car and drive off. We expect a far higher level of training for someone who flies a passenger plane, and we expect aeroplane pilots to carry out a far larger number of checks and to answer questions from air traffic control before they are cleared to take off. That is not excessive; it is a common-sense approach that reflects that there are far higher risks involved in flying a plane full of people above a crowded city than in driving a car. That is the approach that my hon. Friend's amendment 488 would take. I urge hon. Members to support it.

**Stephen Kinnock:** This group of amendments relates to clause 42, which contains the commencement provisions.

Amendment 547, in the name of my hon. Friend the Member for Spen Valley, provides that clauses relating to the office of the voluntary assisted dying commissioner, which will be introduced under her new clause 14 and new schedule 1, would come into force one year after the Act is passed. Subsection (4) of new clause 14, which relates to the functions of the commissioner, including arranging the work of panels and monitoring the operation of the Bill, would not come into force at this point. The amendment would require the process of recruiting the commissioner and their deputy to begin shortly after Royal Assent. Powers to second staff under schedule 1 may be a necessary tool in resourcing the commissioner in the interim period before the wider Bill comes into force.

Amendment 531 would require the Secretary of State to lay before Parliament a report before assisted dying can be provided and is decriminalised. That report must contain an analysis of the readiness of services to provide assistance and of the training that has been provided under the Bill. The effect of the amendment might be to delay the commencement of the Bill until the specified reports have been laid before Parliament.

Amendment 488 would remove clause 42(3), which provides that any provisions that are not already in force two years after the Act is passed will come into force at that point. That would mean that the Secretary of State will need to make regulations to bring into force all provisions of the Bill except clauses 37 to 41 and clauses 43, which come into force when the Act is passed. In addition, the amendment provides that clause 18 may not be brought into force until a Minister of the Crown has made a statement to both Houses of Parliament that all regulations necessary for the effective provision of assistance have been made. The Minister's statement must list those regulations. The amendment does not specify which regulations are necessary for the effective provision of assistance, which could create uncertainty. Amendment 489, which is linked to amendment 488, would likewise remove clause 42(3).

As the Bill stands, provisions that have not already been brought into force will automatically come into force two years after the date on which the Act passes. Amendment 548, tabled by my hon. Friend the Member for Spen Valley and drafted with the technical support of Government officials and lawyers, would change that provision from two years to four years.

We have already discussed the proposition to have regular reports on progress towards implementation, as per amendment 546 and new clause 40. The time required to prepare for the implementation of the Bill is clearly a critical point to be weighed when considering the question of workability. Were Parliament to approve the provision of assisted dying services, it would be the role of Government to ensure that a fully functioning, safe and high-quality service is in place for those who wish to access the assistance provided for under the Bill. The delivery of an entirely new service with robust safeguards will need to be carefully and thoroughly developed and tested.

As the Bill has rightly been amended by Members in Committee and several new requirements have been added, the Government now have to assess the critical path to implementation. We will therefore provide clarity to Members, ahead of Report, as to whether any further amendments related to commencement are needed. We will continue to develop our thinking on the matter and will work with my hon. Friend the Member for Spen Valley to explore the potential options for Report, to capture the need both for timely implementation and for ensuring the provision of a high-quality service for people seeking assistance under the Bill.

Amendment 536 would increase the length of time specified under clause 42(3) from two years to five years. That would mean that any provisions that had not been commenced five years after the date on which the Act is passed will automatically come into force at that time.

I turn to amendment 535. As the Bill stands, the Secretary of State may make regulations to commence the provisions of the Bill for England and Wales. The amendment would, in relation to Wales, require Welsh

[*Stephen Kinnock*]

Ministers instead of the Secretary of State to commence the Bill via regulations. Apart from clauses 37 to 41 and 43, which would come into force on Royal Assent, the provisions of the Bill would come into force in Wales on a date or dates appointed by Welsh Ministers in regulations. There would be no automatic two-year backstop for those provisions to come into force in Wales.

The amendment would also require that regulations made by Welsh Ministers be subject to the affirmative resolution procedure in the Senedd. That may have devolution settlement consequences, as the impact could be that the Bill is differentially commenced in England and Wales, potentially creating a disparity, particularly in relation to the introduction of the criminal offences, and a lack of certainty.

I turn to amendment 490. As the Bill stands, regulations made under clause 42(2) will be subject to the negative resolution procedure. The amendment would change the regulation-making procedure so that the Secretary of State could not make commencement regulations unless a draft is laid before and approved by each House of Parliament. It would also add a new requirement that the Secretary of State may not lay the draft regulations until they have laid a report before each House that provides an analysis of the expected efficacy of services and functions performed under the Bill. The amendment provides a non-exhaustive list of the information that the report must contain. The amendment could cause delays to the making of commencement regulations under the Bill.

*Amendment 547 agreed to.*

*Amendment proposed:* 531, in clause 42, page 24, line 21, at end insert—

“(2A) The Secretary of State may not make a statutory instrument containing (whether alone or with other provision) regulations under subsection (2) bringing sections 1 or 24 into force unless they have previously laid before Parliament a report containing an analysis of—

- (a) the readiness of services to provide assistance and related functions of this Act, and
- (b) training that has been provided under the provisions of this Act.”—(*Sarah Olney*.)

*Question put, That the amendment be made.*

*The Committee divided: Ayes 8, Noes 15.*

#### **Division No. 79]**

##### **AYES**

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

##### **NOES**

Abbott, Jack	Malthouse, rh Kit
Atkinson, Lewis	Opher, Dr Simon
Charalambous, Bambos	Richards, Jake
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 negated.*

*Amendment proposed:* 489, in clause 42, page 24, line 22, leave out subsection (3).—(*Naz Shah*.)

*This amendment would remove the automatic coming into force of provisions under the Act two years after it is passed.*

*Question put, That the amendment be made.*

*The Committee divided: Ayes 8, Noes 15.*

#### **Division No. 80]**

##### **AYES**

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

##### **NOES**

Abbott, Jack	Malthouse, rh Kit
Atkinson, Lewis	Opher, Dr Simon
Charalambous, Bambos	Richards, Jake
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 negated.*

*Amendment proposed:* 548, clause 42, page 24, line 23, leave out “2” and insert “4”.—(*Kim Leadbeater*.)

*This amendment provides that any provision of the Bill not brought fully into force before the end of the period of 4 years beginning with the day on which the Bill is passed will come into force at the end of that period.*

*Question put, That the amendment be made.*

*The Committee divided: Ayes 22, Noes 1.*

#### **Division No. 81]**

##### **AYES**

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

##### **NOES**

Gordon, Tom

*Question accordingly agreed to.*

*Amendment 548 agreed to.*

10.15 pm

**The Chair:** There is no shame in being in a minority of one.

*Amendment proposed:* 535, in clause 42, page 24, line 25, at end insert—

“(3A) Subsections (2) and (3) do not apply in relation to Wales.

(3B) In relation to Wales, the provisions of this Act not brought into force by subsection (1) come into force on such day or days as the Welsh Ministers may by regulations appoint (and such regulations may not be made unless a draft of the statutory instrument containing them has been laid before, and approved by a resolution of, Senedd Cymru).”—(*Sarah Olney*.)

*Question put*, That the amendment be made.

*The Committee divided*: Ayes 12, Noes 11.

**Division No. 82]**

**AYES**

Abbott, Jack	Kruger, Danny
Atkinson, Lewis	Olney, Sarah
Campbell, Juliet	Paul, Rebecca
Francis, Daniel	Saville Roberts, rh Liz
Green, Sarah	Shah, Naz
Joseph, Sojan	Woodcock, Sean

**NOES**

Charalambous, Bambos	Opher, Dr Simon
Gordon, Tom	Richards, Jake
Hopkins, Rachel	Sackman, Sarah
Kinnock, Stephen	Shastri-Hurst, Dr Neil
Leadbeater, Kim	Tidball, Dr Marie
Malthouse, rh Kit	

*Question accordingly agreed to.*

*Amendment 535 agreed to.*

*Amendment proposed*: 490, in clause 42, page 24, line 30, at end insert—

“(7) The Secretary of State may not make a statutory instrument containing (whether alone or with other provision) regulations under subsection (2) unless a draft of the instrument has been laid before, and approved by a resolution of, each House of Parliament.

(8) The Secretary of State may not lay a draft of an instrument under subsection (7) unless they have already laid before each House of Parliament a report providing an analysis of the expected efficacy of services and functions performed under this Act.

(9) The report under subsection (8) must, in particular, set out—

- (a) the extent to which the Act is expected to meet its aim of allowing adults who are terminally ill, subject to safeguards and protections, to request and be provided with assistance to end their own lives;
- (b) an assessment of the availability, quality and distribution of appropriate health services to persons with palliative care needs, including—
  - (i) pain and symptom management;
  - (ii) psychological support for those persons and their families;
  - (iii) information about palliative care and how to access it;
- (c) any concerns with the operation of this Act which have been raised; and
- (d) the Secretary of State’s response to any such concerns and planned actions to be taken in response to those concerns.”—(*Sarah Olney.*)

*This amendment would change the procedure for commencement orders to the affirmative procedure and require a report to have been laid providing an analysis of the likely impact of the Act.*

*Question put*, That the amendment be made.

*The Committee divided*: Ayes 8, Noes 15.

**Division No. 83]**

**AYES**

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

**NOES**

Abbott, Jack	Malthouse, rh Kit
Atkinson, Lewis	Opher, Dr Simon
Charalambous, Bambos	Richards, Jake
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 negated.*

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

*The Committee divided*: Ayes 15, Noes 8.

**Division No. 84]**

**AYES**

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

**NOES**

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

*Question accordingly agreed to.*

*Clause 42, as amended, ordered to stand part of the Bill.*

**The Chair:** We now come to a sequence of pre-debated items. Unless anybody is feeling faint, I am going to see how we get on. Can I take some soundings: is everybody all right?

**Hon. Members indicated assent.**

**The Chair:** Let’s give it a whirl and see where we get to. If I fall over, somebody else will have to come and take the Chair.

*Clause 43 ordered to stand part of the Bill.*

**New Clause 8**

**DUTY TO CONSULT BEFORE MAKING REGULATIONS**

“(1) Before making regulations under section 5, 7, 8, 13, 19 or 21, the Secretary of State must consult—

- (a) the Commission for Equality and Human Rights, and
- (b) such other persons as the Secretary of State considers appropriate.

(2) The persons to be consulted under subsection (1)(b) must include —

- (a) persons appearing to the Secretary of State to have expertise in matters relating to whether persons have capacity, and
- (b) persons appearing to the Secretary of State to have expertise in matters relating to whether persons have been coerced,

unless the Secretary of State considers that, having regard to the subject-matter of the proposed regulations, it would not be appropriate to consult such persons.”—(*Kim Leadbeater.*)

*This new clause imposes a duty to consult before making regulations under various provisions of the Bill.*

*Brought up, read the First and Second time, and added to the Bill.*

### New Clause 14

#### VOLUNTARY ASSISTED DYING COMMISSIONER

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

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

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

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

(4) The Commissioner’s principal functions are—

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

(5) In this Act ‘the Commissioner’ means the Voluntary Assisted Dying Commissioner.

(6) Schedule (*The Voluntary Assisted Dying Commissioner*) makes provision about the Commissioner.”—(*Kim Leadbeater.*)

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

*Brought up, and read the First time.*

*Question put, That the clause be read a Second time.*

*The Committee divided: Ayes 15, Noes 8.*

### Division No. 85]

#### AYES

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

#### NOES

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

*Question accordingly agreed to.*

*New clause 14 read a Second time, and added to the Bill.*

### New Clause 15

#### REFERRAL BY COMMISSIONER OF CASE TO MULTIDISCIPLINARY PANEL

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

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

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

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

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

(4) Schedule (*Assisted Dying Review Panels*) makes provision about Assisted Dying Review Panels.”—(*Kim Leadbeater.*)

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

*Brought up, read the First and Second time, and added to the Bill.*

### New Clause 17

#### RECONSIDERATION OF PANEL DECISIONS REFUSING CERTIFICATE OF ELIGIBILITY

“(1) This section applies where—

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

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

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

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

(4) On the application—

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

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

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

- (a) the person who made the application;
- (b) the coordinating doctor;

- (c) any other person specified in regulations made by the Secretary of State.”—(*Kim Leadbeater.*)

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

*Brought up, and read the First and Second time.*

*Amendment proposed to new clause 17: (a), for subsections (1) to (3) substitute*

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

*Question put, That the amendment be made.*

*The Committee divided: Ayes 3, Noes 20.*

#### **Division No. 86]**

##### **AYES**

Kruger, Danny  
Olney, Sarah

Paul, Rebecca

##### **NOES**

Abbott, Jack  
Atkinson, Lewis  
Campbell, Juliet  
Charalambous, Bambos  
Francis, Daniel  
Gordon, Tom  
Green, Sarah  
Hopkins, Rachel  
Joseph, Sojan  
Kinnock, Stephen

Leadbeater, Kim  
Malthouse, rh Kit  
Opher, Dr Simon  
Richards, Jake  
Sackman, Sarah  
Saville Roberts, rh Liz  
Shah, Naz  
Shastri-Hurst, Dr Neil  
Tidball, Dr Marie  
Woodcock, Sean

*Question accordingly negated.*

*Question put, That the clause be added to the Bill.*

*The Committee divided: Ayes 20, Noes 3.*

#### **Division No. 87]**

##### **AYES**

Abbott, Jack  
Atkinson, Lewis  
Campbell, Juliet  
Charalambous, Bambos  
Francis, Daniel  
Gordon, Tom  
Green, Sarah  
Hopkins, Rachel  
Joseph, Sojan  
Kinnock, Stephen

Leadbeater, Kim  
Malthouse, rh Kit  
Opher, Dr Simon  
Richards, Jake  
Sackman, Sarah  
Saville Roberts, rh Liz  
Shah, Naz  
Shastri-Hurst, Dr Neil  
Tidball, Dr Marie  
Woodcock, Sean

##### **NOES**

Kruger, Danny  
Olney, Sarah

Paul, Rebecca

*Question accordingly agreed to.*

*New clause 17 added to the Bill.*

### **New Clause 19**

#### **RECORDING OF PRELIMINARY DISCUSSION**

“(1) This section applies where a registered medical practitioner (‘the practitioner’) conducts a preliminary discussion with a person.

(2) Where the practitioner is a practitioner with the person’s GP practice, they must, as soon as practicable, record the preliminary discussion in the person’s medical records.

(3) In any other case—

(a) the practitioner must, as soon as practicable, give a written record of the preliminary discussion to a registered medical practitioner with the person’s GP practice, and

(b) that registered medical practitioner must, as soon as practicable, include the record in the person’s medical records.”—(*Kim Leadbeater.*)

*This new clause requires a practitioner to include, in the person in question’s medical records, a record of a preliminary discussion under clause 4.*

*Brought up, read the First and Second time, and added to the Bill.*

### **New Clause 21**

#### **DETERMINATION BY PANEL OF ELIGIBILITY FOR ASSISTANCE**

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

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

(a) that the requirements of sections 5 to 9 have been met in relation to—

(i) the first declaration,

(ii) the first assessment and the report under section 7 on that assessment, and

(iii) the second assessment and the report under section 8 on that assessment;

(b) that the person is terminally ill;

(c) that the person has capacity to make the decision to end their own life;

(d) that the person was aged 18 or over at the time the first declaration was made;

(e) that before making the first declaration, but when the person was aged 18 or over, a registered medical practitioner conducted a preliminary discussion with the person;

(f) that the person is ordinarily resident in England and Wales and has been so resident for at least 12 months ending with the date of the first declaration;

(g) that the person is registered as a patient with a general medical practice in England or Wales;

(h) that the person has a clear, settled and informed wish to end their own life;

(i) that the person made the first declaration voluntarily and was not coerced or pressured by any other person into making that declaration.

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

(4) The panel—

(a) must hear from, and may question, the coordinating doctor or the independent doctor (and may hear from and question both);

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

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

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

(6) The panel—

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

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

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

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

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

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

*Brought up, and read the First time.*

*Question put, That the clause be read a Second time.*

*The Committee divided: Ayes 15, Noes 8.*

**Division No. 88]**

**AYES**

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

**NOES**

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

*Question accordingly agreed to.*

*Clause read a Second time.*

10.30 pm

*Amendment proposed to new clause 21: (d), in subsection (4) for paragraphs (a) to (e) substitute*

*“(a) must hear from, and must question, the coordinating doctor and the independent doctor;*

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

*Question put, That the amendment be made.*

*The Committee divided: Ayes 9, Noes 14.*

**Division No. 89]**

**AYES**

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

**NOES**

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

*Question accordingly negated.*

*Amendment proposed to new clause 21: (c), after subsection (4)(e) insert*

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

*Question put, That the amendment be made.*

*The Committee divided: Ayes 8, Noes 15.*

**Division No. 90]**

**AYES**

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

**NOES**

Abbott, Jack	Malthouse, rh Kit
Atkinson, Lewis	Opher, Dr Simon
Charalambous, Bambos	Richards, Jake
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 negated.*

*Amendment made to new clause 21:* (e), after subsection (4) insert

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

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

*Question put,* That the amendment be made.

*The Committee divided:* Ayes 3, Noes 20.

#### Division No. 91]

##### AYES

Kruger, Danny  
Olney, Sarah

Paul, Rebecca

##### NOES

Abbott, Jack  
Atkinson, Lewis  
Campbell, Juliet  
Charalambous, Bambos  
Francis, Daniel  
Gordon, Tom  
Green, Sarah  
Hopkins, Rachel  
Joseph, Sojan  
Kinnock, Stephen

Leadbeater, Kim  
Malthouse, rh Kit  
Opher, Dr Simon  
Richards, Jake  
Sackman, Sarah  
Saville Roberts, rh Liz  
Shah, Naz  
Shastri-Hurst, Dr Neil  
Tidball, Dr Marie  
Woodcock, Sean

*Question accordingly negated.*

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

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

*Question put,* That the amendment be made.

*The Committee divided:* Ayes 3, Noes 20.

#### Division No. 92]

##### AYES

Kruger, Danny  
Olney, Sarah

Paul, Rebecca

##### NOES

Abbott, Jack  
Atkinson, Lewis  
Campbell, Juliet  
Charalambous, Bambos  
Francis, Daniel  
Gordon, Tom  
Green, Sarah  
Hopkins, Rachel  
Joseph, Sojan  
Kinnock, Stephen

Leadbeater, Kim  
Malthouse, rh Kit  
Opher, Dr Simon  
Richards, Jake  
Sackman, Sarah  
Saville Roberts, rh Liz  
Shah, Naz  
Shastri-Hurst, Dr Neil  
Tidball, Dr Marie  
Woodcock, Sean

*Question accordingly negated.*

*New clause 21, as amended, added to the Bill.*

#### 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.”—(*Kim Leadbeater.*)

*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).*

*Brought up, read the First and Second time, and added to the Bill.*

#### New Clause 36

##### VOLUNTARY ASSISTED DYING SERVICES: ENGLAND

“(1) The Secretary of State must by regulations make provision securing that arrangements are made for the provision of voluntary assisted dying services in England.

(2) In this section ‘commissioned VAD services’ means services provided by virtue of regulations under subsection (1).

(3) The Secretary of State may by regulations make other provision about voluntary assisted dying services in England (whether or not the services are commissioned VAD services).

(4) Regulations under this section may for example provide that specified references in the National Health Service Act 2006 to the health service continued under section 1(1) of that Act include references to commissioned VAD services.

(5) Regulations under this section must provide that section 1(4) of that Act (services to be provided free of charge except where charging expressly provided for) applies in relation to commissioned VAD services.

(6) Regulations under this section may make any provision that could be made by an Act of Parliament; but they may not amend this Act.

(7) In this section ‘voluntary assisted dying services’ means—

(a) services for or in connection with the provision of assistance to a person to end their own life in accordance with this Act, and

(b) any other services provided by health professionals for the purposes of any of sections 4 to 22 except section (Determination by panel of eligibility for assistance).”  
—(*Kim Leadbeater.*)

*This new clause imposes a duty on the Secretary of State to make regulations securing that arrangements are made for the provision of voluntary assisted dying services in England. It also confers a power to make other provision about voluntary assisted dying services in England.*

*Brought up, and read the First time.*

*Question put,* That the clause be read a Second time.

*The Committee divided:* Ayes 15, Noes 8.

#### Division No. 93]

##### AYES

Abbott, Jack  
Atkinson, Lewis  
Charalambous, Bambos  
Gordon, Tom

Green, Sarah  
Hopkins, Rachel  
Kinnock, Stephen  
Leadbeater, Kim

Malthouse, rh Kit  
Opher, Dr Simon  
Richards, Jake  
Sackman, Sarah

Saville Roberts, rh Liz  
Shastri-Hurst, Dr Neil  
Tidball, Dr Marie

**NOES**

Campbell, Juliet  
Francis, Daniel  
Joseph, Sojan  
Kruger, Danny

Olney, Sarah  
Paul, Rebecca  
Shah, Naz  
Woodcock, Sean

*Question accordingly agreed to.*

*Clause read a Second time.*

*Amendment proposed to new clause 36: (a), at end of subsection (1) insert—*

“(1A) Regulations under subsection (1) cannot authorise the National Health Service in England to provide voluntary assisted dying services.”—(*Danny Kruger.*)

*Question put, That the amendment be made.*

*The Committee divided: Ayes 3, Noes 20.*

**Division No. 94]****AYES**

Kruger, Danny  
Olney, Sarah

Paul, Rebecca

**NOES**

Abbott, Jack  
Atkinson, Lewis  
Campbell, Juliet  
Charalambous, Bambos  
Francis, Daniel  
Gordon, Tom  
Green, Sarah  
Hopkins, Rachel  
Joseph, Sojan  
Kinnock, Stephen

Leadbeater, Kim  
Malthouse, rh Kit  
Opher, Dr Simon  
Richards, Jake  
Sackman, Sarah  
Saville Roberts, rh Liz  
Shah, Naz  
Shastri-Hurst, Dr Neil  
Tidball, Dr Marie  
Woodcock, Sean

*Question accordingly negated.*

*Amendment proposed to new clause 36: (c), after subsection (1) insert—*

“(1A) Regulations under subsection (1) cannot authorise a body other than a public authority to provide voluntary assisted dying services if that body is to be contracted by a public authority to do so.”—(*Sarah Olney.*)

*Question put, That the amendment be made.*

*The Committee divided: Ayes 8, Noes 15.*

**Division No. 95]****AYES**

Campbell, Juliet  
Francis, Daniel  
Joseph, Sojan  
Kruger, Danny

Olney, Sarah  
Paul, Rebecca  
Shah, Naz  
Woodcock, Sean

**NOES**

Abbott, Jack  
Atkinson, Lewis  
Charalambous, Bambos  
Gordon, Tom  
Green, Sarah  
Hopkins, Rachel  
Kinnock, Stephen  
Leadbeater, Kim

Malthouse, rh Kit  
Opher, Dr Simon  
Richards, Jake  
Sackman, Sarah  
Saville Roberts, rh Liz  
Shastri-Hurst, Dr Neil  
Tidball, Dr Marie

*Question accordingly negated.*

*Amendment proposed to new clause 36: (d), leave out subsection (6).—(Sarah Olney.)*

*Question put, That the amendment be made.*

*The Committee divided: Ayes 8, Noes 14.*

**Division No. 96]****AYES**

Campbell, Juliet  
Francis, Daniel  
Joseph, Sojan  
Kruger, Danny

Olney, Sarah  
Paul, Rebecca  
Shah, Naz  
Woodcock, Sean

**NOES**

Abbott, Jack  
Atkinson, Lewis  
Charalambous, Bambos  
Gordon, Tom  
Green, Sarah  
Hopkins, Rachel  
Kinnock, Stephen

Leadbeater, Kim  
Malthouse, rh Kit  
Opher, Dr Simon  
Richards, Jake  
Sackman, Sarah  
Saville Roberts, rh Liz  
Shastri-Hurst, Dr Neil

*Question accordingly negated.*

*Amendment proposed to new clause 36: (e), after subsection (6) insert—*

“(6A) The Secretary of State may not lay a draft statutory instrument before either House of Parliament that makes provision containing (whether alone or with other provision) regulations under subsection (1) unless they also lay before both Houses an impact assessment on such regulations.

(6B) The impact assessment under subsection (6A) must include an assessment of the impact of such regulations on the workforce of health professionals and on the National Health Service.”—(*Sarah Olney.*)

*Question put, That the amendment be made.*

*The Committee divided: Ayes 8, Noes 14.*

**Division No. 97]****AYES**

Campbell, Juliet  
Francis, Daniel  
Joseph, Sojan  
Kruger, Danny

Olney, Sarah  
Paul, Rebecca  
Shah, Naz  
Woodcock, Sean

**NOES**

Abbott, Jack  
Atkinson, Lewis  
Charalambous, Bambos  
Gordon, Tom  
Green, Sarah  
Hopkins, Rachel  
Kinnock, Stephen

Leadbeater, Kim  
Malthouse, rh Kit  
Opher, Dr Simon  
Richards, Jake  
Sackman, Sarah  
Saville Roberts, rh Liz  
Shastri-Hurst, Dr Neil

*Question accordingly negated.*

*Question put, That the clause be added to the Bill.*

*The Committee divided: Ayes 14, Noes 8.*

**Division No. 98]****AYES**

Abbott, Jack  
Atkinson, Lewis  
Charalambous, Bambos  
Gordon, Tom  
Green, Sarah  
Hopkins, Rachel  
Kinnock, Stephen

Leadbeater, Kim  
Malthouse, rh Kit  
Opher, Dr Simon  
Richards, Jake  
Sackman, Sarah  
Saville Roberts, rh Liz  
Shastri-Hurst, Dr Neil



**NOES**

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

*Question accordingly agreed to.  
New clause 36 added to the Bill.*

**New Clause 37****VOLUNTARY ASSISTED DYING SERVICES: WALES**

“(1) The Welsh Ministers may by regulations make provision about voluntary assisted dying services in Wales, including provision securing that arrangements are made for the provision of such services.

(2) Regulations under subsection (1) may make any provision that—  
(a) could be made by an Act of Senedd Cymru, and  
(b) would be within the legislative competence of the Senedd if it were contained in such an Act.

(3) The Secretary of State may by regulations make provision about voluntary assisted dying services in Wales.

(4) Regulations under subsection (3) may make any provision that—  
(a) could be made by an Act of Parliament, and  
(b) would not be within the legislative competence of the Senedd if it were contained in an Act of the Senedd.

(5) Regulations under this section may not amend this Act.

(6) In this section ‘voluntary assisted dying services’ has the meaning given by section (Voluntary assisted dying services: England).”—  
(*Kim Leadbeater.*)

*This new clause confers a power on the Welsh Ministers to make provision about voluntary assisted dying services in Wales, including provision securing that arrangements are made for the provision of such services. It also confers a power on the Secretary of State to make provision about such services, where the provision would be outside the legislative competence of Senedd Cymru.*

*Brought up, read the First and Second time, and added to the Bill.*

**New Clause 38****INFORMATION SHARING**

“(1) The Commissioner may disclose information to a person within subsection (3), for the purposes of any function of either of them.

(2) A person within subsection (3) may disclose information to the Commissioner, for the purposes of any function of either of them.

(3) The persons within this subsection are—  
(a) the Care Quality Commission;  
(b) the General Medical Council;  
(c) the General Pharmaceutical Council;  
(d) the Nursing and Midwifery Council;  
(e) any other person specified in regulations made by the Secretary of State.

(4) The Commissioner and the Secretary of State may disclose information to each other, for the purposes of—

(a) any function of the Commissioner, or  
(b) any function of the Secretary of State relating to the operation of this Act.”—(*Kim Leadbeater.*)

*This new clause enables the sharing of information between the Voluntary Assisted Dying Commissioner and certain persons.*

*Brought up, read the First and Second time, and added to the Bill.*

**New Clause 39****OBLIGATIONS OF CONFIDENCE ETC**

“(1) A disclosure of information which is required or authorised by or under this Act does not breach—

(a) any obligation of confidence owed by the person making the disclosure, or

(b) any other restriction on disclosure (however imposed).

This is subject to subsection (2).

(2) This Act does not (and regulations under it may not) require or authorise the disclosure of information which would contravene the data protection legislation (but in determining whether a disclosure required or authorised by or under this Act would do so, the requirement or authorisation is to be taken into account).

(3) In this section “the data protection legislation” has the same meaning as in the Data Protection Act 2018 (see section 3 of that Act).”—(*Kim Leadbeater.*)

*This new clause provides that disclosures on information required or authorised by or under the Bill do not breach any restrictions on disclosure, but that this is subject to the data protection legislation.*

*Brought up, read the First and Second time, and added to the Bill.*

**New Clause 40****REPORTING ON IMPLEMENTATION OF ACT**

“(1) As soon as reasonably practicable after the end of each reporting period, the Secretary of State must prepare and publish, and lay before Parliament, a report about—

(a) progress made in that period in connection with the implementation of this Act, and

(b) the Secretary of State’s plans for implementing the Act in subsequent reporting periods (including the expected timetable for implementation).

(2) For the purposes of this section the reporting periods are—

(a) the period of one year beginning with the day on which this Act is passed;

(b) each subsequent period of 6 months (subject to subsection (3)).

(3) The sixth reporting period under subsection (2)(b) is the last reporting period.”—(*Kim Leadbeater.*)

*This new clause requires the Secretary of State to make, publish and lay before Parliament a report about implementation of the Act resulting from this Bill. The first report must be made as soon as reasonably practicable after the first anniversary of the Act being passed, with subsequent reports being made in respect of the six subsequent 6 month periods.*

*Brought up, read the First and Second time, and added to the Bill.*

**The Chair:** I will suspend the Committee for 15 minutes. We will return at 11 pm.

10.46 pm

*Sitting suspended.*

11.2 pm

*On resuming—*

**New Clause 9****ADVERTISING OFFENCES: SERVICES OF COORDINATING AND INDEPENDENT DOCTORS**

(1) A person who in the course of a business publishes an advertisement, or causes one to be published, for services outlined in subsection (4), is guilty of an offence.

(2) A person who in the course of a business prints, devises or distributes an advertisement for the promotion of services for the services outlined in subsection (4), or causes such an advertisement to be so printed, devised or distributed, is guilty of an offence.

(3) Distributing an advertisement includes transmitting it in electronic form, participating in doing so, and providing the means of transmission.

(4) The services outlined in this subsection are—

- (a) acting as a coordinating doctor under this Act;
- (b) acting as an independent doctor under this Act.

(5) A person guilty of an offence under this section is liable—

- (a) on summary conviction to a fine;
- (b) on conviction on indictment to imprisonment for a term not exceeding 2 years, or a fine, or both.—  
(*Rebecca Paul.*)

*This new clause would make it an offence to publish, print, distribute or devise an advertisement for services of a coordinating doctor or an independent doctor under this Act.*

*Brought up, and read the First time.*

**Rebecca Paul:** I beg to move, That the clause be read a Second time.

The new clause would make the advertising of services by a co-ordinating and/or independent doctor by a person in the course of a business an offence with a sentence of up to two years in prison or a fine or both. As we have discussed previously, we will likely see private provision of assisted dying services, if the Bill is approved. That will create a potentially lucrative opportunity for private businesses, particularly if provision on the NHS is not consistent across the country or is overwhelmed.

“Advertising” means the techniques used to bring attention to a product or service with the aim of presenting it as something a potential customer might need or want. The overarching aim of advertising by a business is to ultimately sell more of a product or service. We must keep that overarching reason in mind when considering the amendment. It would be incredibly inappropriate for such services to be advertised on billboards, public transport or daytime telly, targeting those who may be approaching the end of their life, with ads run repeatedly along with those for stairlifts and life insurance. Such advertising could also undermine our national suicide prevention strategy by normalising suicide in certain situations. It becomes much harder to say to people that suicide is not the answer if we are content to say that it is in certain situations.

I can only imagine some of the difficult conversations that could be generated from an advert seen by a young girl or boy already battling with suicidal thoughts. How does a parent or guardian explain why suicide is not right for them? Imagine the potential impact on men, too. As we all know, suicide is a leading cause of death in men in this country. In 2022, for males between the ages of 20 and 34, one in four deaths was categorised as “intentional self-harm” or “event of undetermined intent”. That is a shocking statistic. That is why banning the advertising of such services is so important.

**Dr Neil Shastri-Hurst** (Solihull West and Shirley) (Con): My hon. Friend is making a passionate argument. I think most of us would agree that billboards and television adverts would be egregious. I note that subsection (3) talks about “electronic form”. That could involve email correspondence between parties. How would that not be an advertisement under the amendment?

**Rebecca Paul:** I think we would be talking about an advert via electronic form, marketing a particular service. We would have to go back to the meaning of “advert”

to answer that. Obviously, there are broader ways of advertising on social media and so on, which I also seek to prevent with the amendment.

That is why banning the advertising of such services is so important, so that a pro-suicide message is not inadvertently delivered to millions of people who assisted dying is not appropriate for. We have to recognise that there are vulnerable people out there who could be influenced by it. It is my view that conversations about assisted dying should happen in person, between the relevant doctor and the patient; they should not be prompted by a TV ad or something seen on a bus. Ads should not be coming up on someone’s Facebook feed every time they log on.

I hope Committee members will support this common-sense amendment. I think that for it to be properly effective, it needs to be expanded to also cover clinics or other organisations advertising assisted dying services more broadly. I very much welcome the opportunity to work with Ministers and the Bill’s sponsor to get this right, if the Committee is disposed to supporting such an amendment.

**Naz Shah:** Does the hon. Lady agree that banning advertising also mitigates the issue of advertising to young people? She mentioned young people and suicide from a social media perspective. Young people, or anybody else who has an eating disorder, may see that as an option to enable them to qualify for assisted dying. That is because, under the Bill as it stands, they would qualify for it if they were termed terminally ill due to their eating disorder.

**Rebecca Paul:** I completely agree. That is exactly what the amendment is intended to do. We are trying to prevent advertising of an inappropriate service to inappropriate groups. It makes sense, therefore, to effectively ban advertising. I think most people would agree that it would be distasteful and inappropriate to have adverts for assisted dying everywhere people look. I hope that hon. Members will consider supporting the amendment, even if that is in an amended form.

**Lewis Atkinson:** I have great sympathy with the intent behind the amendment, and I would like us to get it into a workable form. The hon. Member for Reigate may wish to confirm this, but there is a similar offence in the Surrogacy Arrangements Act 1985—the advertising of surrogacy arrangements is an offence. The important difference in the Surrogacy Act is that there are some further caveats beyond those in the draft amendment—for example, to ensure that there is not inadvertent creation of offences of the type that the hon. Member for Solihull West and Shirley mentioned. The Surrogacy Act sets out that resulting prosecutions would be carried out only with the approval of the Director of Public Prosecutions, to ensure that such safeguards were in place. Although I await the Minister’s comments, I do not think it is possible to support new clause 9 in its current form, for the reasons that the hon. Gentleman lays out.

We have set out that there will potentially be a small number of doctors providing these services. A GP—not a member of the public—would need to know where to direct their patient. I cannot see how, other than by

having some form of electronic directory or email correspondence, it would be possible for such people to become available.

I am not able to vote for the new clause at this stage, but I will put it on my notepad of things on which I am keen to work with colleagues on Report, perhaps by learning the lessons from the surrogacy advice and taking advice from Minister. I think we all agree that we should not be advertising to the general public and encouraging these services.

**Stephen Kinnoch:** Thank you, Sir Roger, for giving me permission to remove my jacket. It is greatly appreciated. I assume that other hon. Gentlemen in the room are also able to do the same, should they wish to do so.

New clause 9 would make it a criminal offence for a person to advertise their services as a co-ordinating doctor or an independent doctor under the Bill. The offence would apply to a person who, in the course of a business, publishes or causes publication of an advertisement for the services of acting as a co-ordinating doctor or an independent doctor under the Bill, or who prints, devises or distributes an advertisement or causes that for the promotion of such services. The offence is wide-ranging and could include, for example, a person who unknowingly transmitted such advertising via electronic communications or social media.

Should the new clause be passed, further work may be needed to determine how the offence would be enforced. I also note that there is no provision for any defence in relation to the offences—for example, where a person responds to inquiries.

Restrictions on advertising always need careful consideration and drafting, given the potential unintended consequences and European convention on human rights impacts—particularly in relation to article 10, on freedom of speech. That is particularly so when breaches of the restrictions are made a criminal offence, as is the case here. However, article 10 is a qualified right, which means that interference can be justified provided that it is in accordance with the law, pursuant of a legitimate aim and necessary in a democratic society, so although the new clause could engage article 10, it may not violate it.

**Kim Leadbeater:** New clause 9 specifically relates to the advertising of assisted dying services. I fully understand the intent behind it—to prevent the unethical advertising of assisted dying services. I thank the hon. Member for West Worcestershire (Dame Harriett Baldwin) for bringing the issue to the Committee's attention. However, there are important nuances with the new clause as drafted that need to be addressed, to avoid criminalising individuals or organisations simply for providing information that is essential for those seeking access to those services. I have looked into this issue because it is an important point for the Committee to consider.

Section 4 of the Cancer Act 1939, a useful reference point, bans advertising for cancer treatment. It prevents the advertising of any treatments, regardless of whether they are evidence-based. Similarly, as my hon. Friend the Member for Sunderland Central mentioned, the Surrogacy Arrangements Act 1985 prohibits the advertising of

surrogacy services. Both Acts are aimed at protecting individuals from misleading or unethical commercial activity.

The situation with assisted dying is more complex. The new clause is not about advertising unregulated or unproven services; it is actually about doctors who are offering a legal, regulated service to those who meet the criteria. I therefore have the same concerns as the hon. Member for Solihull West and Shirley.

Subsection (3) states:

“Distributing an advertisement includes transmitting it in electronic form, participating in doing so, and providing the means of transmission.”

That is particularly concerning because it could criminalise doctors involved in the process of simply communicating with their patients, such as by sending an email, if they were seen as participating in the distribution of an advert.

The intent is clear: we must prevent the unethical advertising of assisted dying services. However, we must ensure that the new clause does not inadvertently hinder access to legal services by criminalising the actions of doctors who are simply making themselves available in accordance with the law. We must not create barriers for those who need the service, nor should we penalise doctors for providing legitimate, legal services. I recognise the need to prevent the unethical advertising of assisted dying services, especially to avoid commercial exploitation or coercion, but it is essential that we carefully calibrate the clause to ensure that it targets unethical advertising practices without sweeping in legitimate and necessary actions that help people find the care they need in a manner that is lawful and respectful of their autonomy. As such, I am very happy to work with colleagues, including the hon. Member for Reigate, to look at how we can produce something to that effect ahead of Report.

**Rebecca Paul:** I thank everyone for all the very constructive points they made. I completely agree with the points raised; I think some work is needed, but I am pleased that the hon. Member for Spen Valley and other Committee members are willing to work with me and the tabling Member—my hon. Friend the Member for West Worcestershire—to get this measure into a place where it does what we want it to do, without capturing things that we do not want it to capture. I completely take the point on the concern about emails; that is not what we want to capture.

11.15 pm

**Kit Malthouse:** My hon. Friend is making a good point, but I want to make a constructive suggestion. It might be worth our having a look at Switzerland, where advertising is actually banned but the provision of information is not. It is a fine line, but the Swiss seem to get the balance right.

**Rebecca Paul:** I thank my right hon. Friend for that point. He is absolutely right that we can learn from what other jurisdictions have done, leverage that and create an amendment or new clause that works for what we are trying to achieve, and know that it will target the advertising that we seek to target.

**The Chair:** Does the hon. Lady wish to press new clause 9 to a division?

**Rebecca Paul:** Given the spirit of it, I feel like we should. That does not prevent me from tabling it on Report—so yes, I will press it to a vote.

*Question put, That the clause be read a Second time.*

*The Committee divided: Ayes 9, Noes 13.*

#### Division No. 99]

##### AYES

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

##### NOES

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

*Question accordingly negated.*

#### New Clause 10

##### COLLECTION OF INFORMATION ON ASSISTANCE

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

- how the process of providing assistance was carried out,
- the time taken from the ingestion or administration of the substance provided under section 18 to the time of death, and
- 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.—(*Sarah Olney.*)

*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.*

*Brought up, and read the First time.*

*Question put, That the clause be read a Second time.*

*The Committee divided: Ayes 8, Noes 15.*

#### Division No. 100]

##### AYES

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

##### NOES

Abbott, Jack	Gordon, Tom
Atkinson, Lewis	Green, Sarah
Charalambous, Bambos	Hopkins, Rachel

Kinnock, Stephen	Sackman, Sarah
Leadbeater, Kim	Saville Roberts, rh Liz
Malthouse, rh Kit	Shastri-Hurst, Dr Neil
Opher, Dr Simon	Tidball, Dr Marie
Richards, Jake	

*Question accordingly negated.*

#### New Clause 12

##### OBLIGATIONS RELATED TO TRAINING

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

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

- section 5(3)(a),
- section 8(6)(a), or
- section 19(2)(b),

is under any duty to participate in the provision of assisted dying under the terms of this Act.”—(*Daniel Francis.*)

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

*Brought up, and read the First time.*

*Question put, That the clause be read a Second time.*

*The Committee divided: Ayes 8, Noes 15.*

#### Division No. 101]

##### AYES

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

##### NOES

Abbott, Jack	Malthouse, rh Kit
Atkinson, Lewis	Opher, Dr Simon
Charalambous, Bambos	Richards, Jake
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 negated.*

#### New Clause 18

##### PROVISION OF INFORMATION IN ENGLISH AND WELSH

“(1) Any service, report, declaration or certificate of eligibility provided under this Act to a person seeking assistance to end their own life must either be—

- in the person’s first language, if that language is English or Welsh, or
- their preferred language of English or Welsh.

(2) The person’s choice of language under subsection (1) must be recorded in that person’s medical records.

(3) Any regulations made under sections 5, 7, 8, 13 or 21 specifying the form and content of declarations or statements must make provision for their being in both the English and Welsh language.

(4) No regulations that contain provision for the Welsh language under the requirements of subsection (3) may be made unless a draft has been laid before and approved by a resolution of Senedd Cymru.

(5) The Assisted Dying Review panel must make certificates of eligibility available in either English or Welsh depending on the person's choice of language under subsection (1).—(*Liz Saville Roberts.*)

*Brought up, and read the First time.*

**Liz Saville Roberts:** I beg to move, That the clause be read a Second time.

We have received additional evidence from the Welsh Language Commissioner that bears on this new clause quite considerably. The comments result from our discussions of amendments 413, 427 and 428, and amendment (a) to new schedule 2, and it is worth having an interpretation of them on record.

The safeguarding process is a matter of Welsh language legal rights and a clear communicative necessity. The Welsh Language Commissioner says that

“it is essential that Welsh speakers can discuss the decision to end their own life through the medium of Welsh if they so wish.”

The key word here is “discuss”. We are very used in Wales to the convention of documentation and information being available in bilingual forms., However, in previous amendments on the Welsh language, I have endeavoured to make sure that those involved in the process are—to the degree that all reasonable steps have been taken—able to converse with fluent proficiency in the preferred language of the person who comes before them seeking their support and their judgment in relation to capacity and coercion.

Therefore, all reasonable steps should be taken to ensure that the key human aspect of this discussion—the conversations between the person and the co-ordinating doctor, the independent doctor and the panel—should be conducted in Welsh, where that is the preferred language. Welsh speakers should not have to request to be able to use Welsh every time the process moves from one person to another; that should be recognised at the beginning of the process. Again, all reasonable steps should be taken to ensure that people are able to communicate in the language with which they are most naturally comfortable—the language that comes to them when they express perhaps their deepest fears and greatest emotions. On occasion, it will be difficult to find people in a reasonable timespan, and we will need to train people in certain roles, but that is where the “all reasonable steps” requirement comes in.

Forgive me, it is late, but it is important for me to take a little time, because the commissioner notes that there has already been some discussion in Committee about whether provisions are necessary in the Bill. The commissioner goes on to say:

“The Welsh Language Standards (No.7) Regulations 2018 are the relevant standards which apply to health boards and NHS trusts in Wales. Although the standards place duties to provide a range of services through the medium of Welsh (such as correspondence, case conferences, documents and forms), they do not go as far as to place duties on health boards to ensure that Welsh speakers can receive clinical services through the medium of Welsh.”

That is why we need my new clause in the Bill. Legislation as it stands in relation to Wales is not sufficient even to give us the “reasonable steps” provision.

The commissioner says that although in Wales

“Welsh Language standards apply to NHS primary care services that are contracted by the health boards, Welsh language standards currently don't apply to independent providers. However, a limited number of Welsh language duties have been placed on independent primary care providers”—

that is GPs, of course. The commissioner continues:

“As is the case with respect to the Welsh language standards, these duties do not go as far as ensuring that Welsh speakers can receive clinical primary care services through the medium of Welsh.”

That again is why “all reasonable steps” is about doing the best we can to ensure that people are able to communicate in the language that comes most naturally to them.

The commissioner also says:

“It is important to note that the standards set out duties relating to health services in general, while the Bill in question relates to a much more specific and specialised service. It also relates to a highly sensitive issue where being able to provide in an individual's first language is essential. The key point here is that stronger provisions could be made in an area such as assisted dying compared to that which would be practically possible in standards relating to health services more generally. As such, if there is an opportunity to make specific provisions in legislation regarding ensuring clinical services through the medium of Welsh then it should be done.”

I know that there are two concerns, and I have already mentioned the phrase “all reasonable steps”. I want us to have a decision in this place, here and now, and to hear back from the promoter and Ministers that there is an appreciation that we need something in the Bill. The Welsh Language Act 1993, as it applies to the judiciary, gives the individual only the right to speak Welsh; it does not give them the right to discuss or to be understood. Through the written evidence I have quoted, I hope I have been able to show that the Welsh language standards in Wales do not go as far as we need them to in this legislation.

The other point—again, this is part of our finding our way with amendments—is that my understanding is that the new clause would apply to the geographic area of Wales only; it would not apply in England, as is normal with other legislation in this respect.

I want to hear the response from the promoter and Ministers before I decide whether to press my new clause to a vote. However, I do feel, on this final day, that we need to have something on record that says we respect the use of the Welsh language and we will do our best to ensure that the provisions act effectively in that respect.

**Stephen Kinnoch:** The new clause would ensure that anyone seeking assistance under the Bill in England or Wales receives any services, reports, declarations or certificates of eligibility in Welsh if that is their first or preferred language. It is linked to the amendments tabled by the promoter to ensure that the form and content of any statement or declaration be set out in regulations, rather in the schedules to the Bill.

The new clause would require any regulations made specifying the form and content of declarations or statements required in relation to the first declaration, the co-ordinating and independent doctors' assessments, the second declaration and the final statement to make provision for those to be provided in both English and Welsh.

A legal requirement that all services, as well as reports, declarations or certificates of eligibility, must be provided in Welsh, where an individual's first or preferred language is Welsh, would go beyond usual practice in England. Such a requirement may lead to operational issues, such

[Stephen Kinnock]

as there being a reduced pool of registered medical practitioners or assisted dying panel members who are able to carry out the functions under the Bill.

I want to put on record again the Government's continued commitment to devolution and to working with the devolved Governments. The Government have taken a neutral position on the Bill and on the matter of assisted dying, but we are committed to working together with the Welsh Government to resolve any legal and technical issues, and to discussing constitutional matters that might arise.

11.30 pm

**Kim Leadbeater:** I thank the right hon. Member for Dwyfor Meirionnydd for tabling the new clause. She has made extremely valuable points, as she has throughout the Committee, about the importance of respect for the Welsh language. I think she is absolutely right.

As the Minister said, there are some issues with the drafting, as to what the implications would be, not just in Wales but in England. It is my understanding that Ministers in the Senedd are happy to meet following the Committee's proceedings, and I am happy to discuss these issues with them as part of our conversations.

It is important that the right hon. Member's thoughts have been put on record, and we need to look at what we can put in the Bill ahead of Report to address her concerns.

**Liz Saville Roberts:** I honestly feel that the legislation as it stands—the Welsh Language Act 1993, and the 2011 and 2018 standards in relation to health—is not sufficient for what we are endeavouring to do. People have a right to use their first language, and it is of some regret to me that the only two languages protected by law in England and Wales are English and Welsh. I would be happy if there were more, but they are the only two I can discuss, and Welsh is obviously very close to my heart. On this last day, I feel my obligation to push the issue to a vote; otherwise, we will default to legislation that is not sufficient for what we are endeavouring to do.

*Question put, That the clause be read a Second time.*

*The Committee divided: Ayes 12, Noes 11.*

**Division No. 102]**

**AYES**

Abbott, Jack	Kruger, Danny
Campbell, Juliet	Olney, Sarah
Francis, Daniel	Paul, Rebecca
Gordon, Tom	Saville Roberts, rh Liz
Green, Sarah	Shah, Naz
Joseph, Sojan	Woodcock, Sean

**NOES**

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

*Question accordingly agreed to.*

*New clause 18 read a Second time, and added to the Bill.*

**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.”—(Danny Kruger.)

*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*

*Brought up, and read the First time.*

*Question put, That the clause be read a Second time.*

*The Committee divided: Ayes 3, Noes 20.*

**Division No. 103]**

**AYES**

Kruger, Danny	Paul, Rebecca
Olney, Sarah	

**NOES**

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

*Question accordingly negated.*

**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.”—(Rebecca Paul.)

*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.*

*Brought up, and read the First time.*

*Question put, That the clause be read a Second time.*

*The Committee divided: Ayes 3, Noes 20.*

**Division No. 104]**

**AYES**

Kruger, Danny	Paul, Rebecca
Olney, Sarah	

**NOES**

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

*Question accordingly negated.*

**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.”—(Dr Tidball.)

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

*Brought up, read the First and Second time, and added to the Bill.*

**New Clause 28****12-MONTH ASSESSMENT OF THIS ACT**

“(1) The Secretary of State must undertake, prepare and publish an assessment, within 12 months from the day this Act is passed, of—

- (a) the extent to which the Act is on course to meet its aim of allowing adults who are terminally ill, subject to safeguards and protections, to request and be provided with assistance to end their own lives;
- (b) the extent to which the Act is likely to meet that aim;
- (c) an assessment of the state of health and care services to persons with palliative and end of life care needs and the implications of this Act on those services;
- (d) any emerging concerns relating to the current or future operation of the Act; and
- (e) steps the Secretary of State plans to take in response to those concerns.

(2) The assessment in paragraph (1)(c) must include the quality and distribution of appropriate health and care services to persons with palliative and end of life care needs, including—

- (a) pain and symptom management;
- (b) psychological support for those persons and their families; and
- (c) information about palliative care and how to access it.

(3) The Secretary of State must lay any report under subsection (1) before both Houses of Parliament.”—(Daniel Francis.)

*This new clause would require the Secretary of State for Health and Social Care to undertake an assessment of the Act within 12 months, including an assessment of any concerns and services to persons receiving palliative and end of life care and the implications of the Act on those services.*

*Brought up, and read the First time.*

*Question put, That the clause be read a Second time.*

*The Committee divided: Ayes 8, Noes 15.*

**Division No. 105]****AYES**

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

**NOES**

Abbott, Jack	Malthouse, rh Kit
Atkinson, Lewis	Opher, Dr Simon
Charalambous, Bambos	Richards, Jake
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 negated.*

**New Clause 30****RELATIVES SEEKING ASSISTANCE AT THE SAME TIME**

“(1) This section applies where the coordinating doctor, the independent doctor, or any other medical or other healthcare professional involved in the person’s care receives any indication that the person is seeking assistance to end their own life under this Act contemporaneously as any one of their family members.

(2) Such a professional as mentioned in subsection (1) must notify the person's coordinating doctor and a registered medical practitioner from the person's GP practice of the matter as mentioned in subsection (1).

(3) If the assessing doctor is notified of a matter as mentioned in subsection (1), the assessing doctor must—

- (a) refer the person for assessment by a registered medical practitioner who is registered in the specialism of psychiatry in the Specialist Register kept by the General Medical Council,
- (b) refer the person for assessment by a social worker who is registered with Social Work England or Social Care Wales, and
- (c) take account of any opinion provided by that other registered medical practitioner or registered social worker.

(4) Any opinion provided to one assessing doctor under subsection (3)(a) or (b) must be shared with the other assessing doctor.”—(*Jack Abbott.*)

*Brought up, and read the First time.*

**Jack Abbott** (Ipswich) (Lab/Co-op): I beg to move, That the clause be read a Second time.

I am minded not to press the new clause to a vote, but I have a few brief remarks to make. The new clause does what it says on the tin. It applies to the rare—I underline the word “rare”—cases in which two family members, particularly a couple, both receive a terminal diagnosis within a relatively short space of time and would therefore qualify under the Bill.

For very many couples, there would be absolutely nothing untoward. Many people will make a decision in their best interests, particularly if they have been married or partners for a significant period. The new clause stipulates that if any medical or healthcare professional receives any indication that a patient is seeking an assisted death at the same time as one of their family members, especially a partner, both the co-ordinating doctor and a registered medical practitioner from the person's GP practice must be notified and the patient must be referred both for a psychiatric assessment and for an assessment by a social worker. The assessing doctor would then have to take into account any opinion provided by the psychiatrist and social worker and share it with the assessing doctor.

I appreciate that the new clause may be a little too prescriptive at this stage, but I would like the matter to be considered on Report and to be given further deliberation by the Government if the Act is passed and goes into the implementation phase. I think all Committee members can appreciate why such a scenario, rare as it may be, needs to be considered for the reasons we have discussed today in relation to coercion or other sorts of abuse, whether it is obvious or more pernicious. We know that in certain situations there will be people, particularly if they are married or in a long-term partnership, for whom such aspects may be at play. I am sure that they are a rare minority of cases, but I hope that these things are considered. Greater scrutiny is probably needed in these scenarios.

Essentially, the new clause would allow for a more comprehensive and thorough assessment of people's wellbeing and social context, including their relationship. I am not minded to press it to a vote at this stage.

**Stephen Kinnock:** New clause 30 would introduce a duty on medical or other healthcare professionals involved in a person's care, including assessing doctors, should they receive an indication that the person is seeking assistance to end their own life contemporaneously with one of their family members.

The duty has two parts. First, the medical or other healthcare professional who receives the indication must notify the person's co-ordinating doctor and a registered medical practitioner from the person's GP practice. Secondly, if an assessing doctor receives notification of that fact, they must refer that person for assessment by a registered medical practitioner specialising in psychiatry and a registered social worker, and must take account of their opinion. The assessing doctor must share that opinion with the other assessing doctor.

In the absence of definitions, issues could arise as to who is covered by the term “family member” and as to the meaning of “contemporaneously”. The additional referrals would add to the length of the application process.

**Kim Leadbeater:** I thank my hon. Friend the Member for Ipswich for tabling the new clause. I have some concerns around the broad definition of “family member”. I also feel that it would be potentially excessive if there were a coincidental situation in which, tragically, two members of the same family were terminally ill. I worry about the extra burden it would place on them of going through an even more rigorous process when they had both been assessed under the thorough regime of the Bill, including the multidisciplinary panel. However, the point is worth discussing and I welcome the fact that my hon. Friend has raised it.

**Jack Abbott:** I appreciate the points made by the Minister and by my hon. Friend the Member for Spens Valley. “Family member” is a relatively non-specific description, but I think the thrust of the new clause is clear. Clearly, it is directed particularly at couples.

I fully understand why my hon. Friend does not want people to have to go through a huge number of extra layers; I have said at length several times that I do not want people at the end of their life to go through an awful period of sitting in endless meetings, assessments or courtrooms. However, I reiterate that although they would be relatively exceptional, there will be situations in which coercion and other sorts of pressure are potentially at play. I agree that that may be an incredibly rare scenario and that two people may just want to go through the stages towards the end of life together, but extra checks may need to happen at some point to ensure absolutely that there is nothing untoward such as other sorts of pressure or coercion, rare as that might be.

11.45 pm

I will not press new clause 30 to a vote, but I appreciate the opportunity to raise those points. I beg to ask leave to withdraw the motion.

*Clause, by leave, withdrawn.*

### **New Clause 33**

#### COLLECTION OF STATISTICS (No.2)

“(1) The Voluntary Assisted Dying Commissioner must ensure that the statistics specified in Schedule [*Statistics to be collected*] are collected.



(2) The Commissioner must publish a yearly report setting out those statistics.

(3) The Secretary of State may by regulation vary the contents of Schedule [*Statistics to be collected*].—(*Sarah Olney*.)

*Brought up, and read the First time.*

*Question put, That the clause be read a Second time.*

*The Committee divided: Ayes 9, Noes 14.*

#### Division No. 106]

#### AYES

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

#### NOES

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

*Question accordingly negatived.*

#### New Clause 34

##### ASSISTED DYING NOT A MEDICAL TREATMENT

“Assisted dying under this Act shall not be considered to be a medical treatment.”—(*Danny Kruger*.)

*Brought up, and read the First time.*

**Danny Kruger:** I beg to move, That the clause be read a Second time.

This will be my last speech in this Committee, so before I speak to the important principle expressed in new clause 34, may I thank you, Sir Roger, and all your colleagues who have chaired the Committee? I also thank the Clerks, who have done a huge amount of amazing work behind the scenes, and all members of the Committee; I particularly thank the hon. Member for Spen Valley for her good faith and good nature throughout the process. I have great respect for all Committee members. A particular hero was the hon. Member for Southgate and Wood Green, who was the most popular speaker every day. [*Laughter.*] I am looking forward to his final speech.

I pay tribute to all those hon. Members who did not serve on the Committee but contributed to our debates by tabling amendments; I really am encouraged by many of them. I pay particular tribute to the hon. Member for York Central, who has been a very powerful influence on me and has attempted to do very good work with the Committee. I also wish to mention my hon. Friend the Member for Runnymede and Weybridge (Dr Spencer). Perhaps in sympathy with the hon. Member for Harrogate and Knaresborough, the most liberal member of the Committee, he has attempted to create an assisted dying Bill that does justice to the principles of autonomy behind it.

My new clause reflects my hon. Friend’s conception of the Bill. His amendments would have taken assisted dying out of the NHS, and indeed out of healthcare altogether. He was right to try to do that. If we are to do this thing, we should recognise that what we are proposing to legalise is not healthcare. Indeed, new clause 36 recognises the essential incompatibility between the service proposed here and healthcare as it is traditionally understood in our country and enshrined in the NHS Act.

More than that, the foundations of healthcare in the west are contravened by the Bill. The Hippocratic oath contains the promise:

“Neither will I administer a poison to anybody when asked to do so, nor will I suggest such a course.”

That is the oath that doctors take, and it has been the ethical basis of medical practice in the west for millennia. The Bill would be the final, official abandonment of that ethical tradition.

I implore the Committee to reflect on the essential principle that healthcare is the antidote to sickness, whereas this proposal for assisted suicide is the antidote to life. That is the treatment that the Bill proposes to legalise. It is entirely different from healthcare, in principle and in practice. It is therefore no surprise that so many of the professional bodies involved in healthcare regard this proposed treatment as incompatible with their professions. The BMA agrees that this should be a separate service.

I was struck by a *BMJ* article that appeared last November, “Reframing assisted dying through the civil law: possibilities and challenges for the UK”, which was written by a group of palliative care professionals. It sets out how, if assisted dying is to be legalised in this country, it might best be organised and delivered. New clause 34 and all that flows from it would enable us to design a better assisted suicide service than the one that the Bill would give us.

The hon. Member for Spen Valley this morning and the hon. Member for Sunderland Central this afternoon asked how it should be done, if we are to do it. My hon. Friend the Member for Reigate offered some suggestions. I will build on what she said by saying how I think the Bill should have been framed—indeed, how I and others, through the amendments we have tabled, have tried to ensure it is framed.

We have tried to match the Bill to the campaign for assisted suicide. Understandably, there is considerable public support for people at the end of their life, who are at risk of suffering a terrible, agonising death and whom palliative care cannot help, to have the right to end their life a few days or weeks early. We can argue about how many people that is. I think the number of people whom palliative care could not help if we organised our palliative care system properly is infinitesimally small—almost non-existent. However, we disagree on that, so let us assume that there are some people who will fall into that category. The campaign for this Bill is the campaign for those people to have the right to an assisted death, but that is not what we have in the Bill. What we have is a right for anybody who in the opinion of two doctors might reasonably be expected to die within six months to request and receive lethal drugs, all paid for and assisted by the NHS. That is not what the campaign has been for.

[*Danny Kruger*]

Let me suggest how, if we are to be honest to the campaign, we should design this thing: not as healthcare, but as a compassionate suicide service for people facing physical agony at the very end of their life. As we tried to ensure at the beginning of our deliberations, eligibility would be for people fearing pain, not for those feeling a burden. There would be a proper capacity test, not the Mental Capacity Act 2005 test. There would be proper, meaningful safeguards against coercion. We would have doctors and a multidisciplinary team at the right stage of the process: right at the beginning, at the first assessment. We would have all the appropriate signposting and palliative care provision as an alternative to assisted suicide. We would then have a proper judicial process to decide whether to approve the application.

As for provision, from assessment through to the final act it should not be in the NHS. It should not be provided by any profit-making providers advertising their services and receiving money for every death that they assist, which is what we have probably got with the Bill. It should be provided by non-profit organisations, should be tightly regulated and should be funded not through NHS commissioning or by the patients, but by philanthropy.

The scale of all this is to be discovered, I guess, if we pursue the Bill. It has been suggested that the lower end of the expectation is about 6,000 deaths per year. On the calculations made by the experts in the paper I cited, it would need a budget of about £10 million a year to manage a 6,000-person caseload. That is in the ballpark of what the campaign groups promoting the Bill have been spending, so I do not think that there would be any difficulty in raising that sort of money if it is what people want. After all, hospices have to raise millions of pounds every year to fund their work. I do not see why assisted dying services should not be able, and required, to do the same thing.

There was a way to do this more consistently with the campaign for assisted suicide. For the avoidance of doubt, I would have opposed that too, because even that much more honest and tightly circumscribed service would profoundly alter our society—it would send the signal that some people are better off dead, and I think it would be wrong for our country—but at least it would be honest. It would be consistent with the campaign.

I will end with the observation that what I have just described is what I think the public think the Committee is doing: designing a service like that for the small number of people at the very end of their life who are facing a terrible physical death. That is not what we have done, it is not what the Committee has approved, it is not what the original Bill said and it is not what the Bill now says as we send it back to the House. I hope that the public and our colleagues in Parliament will recognise that this Bill is not the one that they thought they were getting.

**Rebecca Paul:** I rise to support new clause 34, which clarifies that assisted dying is not a medical treatment—not only because of the principle behind it, which I have talked a lot about already, but because of the unintended results. We need to recognise that many laws, rules and regulations have been written using the word “treatment” that never envisaged assisted dying being included. Every bit of law that refers to when treatment can be given,

with or even without consent, such as section 63 of the Mental Health Act 1983, will become a potential problem if assisted dying is technically viewed as a medical treatment. New clause 34 is therefore essential to protect the meaning and integrity of the current law and to protect patients in future.

In written evidence, Professor David Jones points out that there are dangerous consequences to classifying death as a medical treatment. As a general principle, he observes:

“If an effective medical treatment cannot be self-administered orally then other routes should be considered, including those administered by a healthcare professional.”

We can immediately see the problem that will arise if assisted dying is a treatment. The view that such a treatment can be administered by a healthcare professional suddenly moves us into euthanasia territory, which is clearly not the intention of the Bill. Professor Jones goes on to say:

“If a treatment effectively reduces distressing symptoms in one category of patient (adults at the end of life), then it should be considered for treating other categories of patient”.

If we substitute the word “treatment” with “assisted dying”, we get a wholly unacceptable approach that could open the way to offering assisted dying to under-18s, as in Belgium, or to people whose psychological suffering is unbearable, as we have seen in Belgium and the Netherlands with the euthanasia of people with mental health conditions. Finally, Professor Jones says:

“Where a patient does not have capacity to consent to medical treatment then doctors should provide whatever treatment is ‘of overall benefit’ to the patient.”

If we substitute the same words, we can see that once again it leaves us with a big issue.

The Bill already has requirements relating to capacity, age and physical illness, and a requirement for self-administration, but the point is that by classifying assisted dying as a medical treatment we are making those requirements less stable and introducing the potential for conflict within the existing law. We are inviting future Parliaments to question why they are there in the first place. Why arbitrarily restrict this medical treatment when we do not restrict other treatments in the same way?

If we do not rule out assisted dying as a medical treatment, we are potentially opening the Bill up for challenge by the courts when assisted dying treatment is limited to certain groups. That is one reason why the Association for Palliative Medicine has explicitly backed the principle represented in the new clause. It has said in written evidence that defining death as treatment would be “contrary to all prior medical practice and public expectation, and laden with risks of unintended consequences.”

The Bill may look set in stone, but the law can easily be amended in future, for instance by amending a major health Bill. What we decide in this Committee could have major consequences in a few years’ time. I urge that we future-proof the Bill now by explicitly declaring in it that assisted dying is not a medical treatment, so that the issues I have set out will not arise at any point.

12 midnight

**Stephen Kinnock:** I associate myself with the comments of the hon. Member for East Wiltshire about the amazing work of the staff and the Clerks. May I say thank you very much to everybody?

New clause 34 seeks to prevent assisted dying under the Bill from being considered a medical treatment. As drafted, the Bill is silent on the question whether the provision of assistance under the Bill can be considered a treatment. If accepted, the amendment may be interpreted to mean that the term “medical treatment” in any other legislation may not be interpreted to include assisted dying. The term “medical treatment” is used in many different contexts across the statute book and has different meanings according to context. The clause is therefore likely to produce unpredictable and potentially unintended effects.

**Kim Leadbeater:** We are entering deeply philosophical territory, which is welcome and has happened several times before during the Committee’s proceedings. As ever, the hon. Member for East Wiltshire has raised some interesting points, but my view is that his new clause should not be in the Bill. We all have our views on how we frame assisted dying and choice at the end of life, but I do not think that assisted dying should be defined—or rather not defined—in this way in the Bill.

**Rebecca Paul:** Will the hon. Lady give way?

**The Chair:** The hon. Member for Spen Valley is entitled to respond if she so chooses, but I think she has sat down.

**Danny Kruger:** I will press new clause 34 to a vote.

*Question put,* That the clause be read a Second time.

*The Committee divided:* Ayes 2, Noes 21.

#### Division No. 107]

#### AYES

Kruger, Danny

Paul, Rebecca

#### NOES

Abbott, Jack

Malthouse, rh Kit

Atkinson, Lewis

Olney, Sarah

Campbell, Juliet

Opher, Dr Simon

Charalambous, Bambos

Richards, Jake

Francis, Daniel

Sackman, Sarah

Gordon, Tom

Saville Roberts, rh Liz

Green, Sarah

Shah, Naz

Hopkins, Rachel

Shastri-Hurst, Dr Neil

Joseph, Sojan

Tidball, Dr Marie

Kinnock, Stephen

Woodcock, Sean

Leadbeater, Kim

*Question accordingly negatived.*

#### New Clause 35

##### DISABILITY ADVISORY BOARD ON THE IMPLEMENTATION AND IMPLICATIONS OF THE ACT FOR DISABLED PEOPLE

“(1) The Commissioner must, within six months of the Commissioner being appointed under this Act, appoint a Disability Advisory Board to advise on the implementation and impact of this Act in its operation on disabled people.

(2) The Board must include—

- (a) people who have a disability under the Equality Act 2010,
- (b) representatives from disabled people’s organisations, and

- (c) other such persons or organisations as the Commissioner considers relevant to the impact of the Act on disabled people.

(3) Within six months of its appointment, the Advisory Board must report to the Secretary of State and the Commissioner to advise on the implementation of the Act and then annually thereafter report on the impact of the Act’s operation on disabled people.

(4) The Secretary of State must, within three months of receipt of any report under subsection (3), lay the report before both Houses of Parliament.”—(*Dr Tidball.*)

*This new clause would require the Voluntary Assisted Dying Commissioner to establish an advisory board which would report to advise on the implementation of the act six months after its appointment and then report annually thereafter on the impact of the operation of the Act on disabled people.*

*Brought up, and read the First time.*

**Dr Tidball:** I beg to move, That the clause be read a Second time.

This is the final new clause of the Committee. As I said in support of new clause 25 and associated amendments last week, I want to strengthen the voice of disabled people in the Bill. New clause 35 would require the voluntary assisted dying commissioner to establish a disability advisory board that would report annually on the implementation and impact of the Act on disabled people. The new clause has been designed to ensure that disabled people have a voice at the heart of the Bill and an ongoing role in monitoring its impact.

The disability advisory board model reflects a structure that was used at the Department of Health to implement the Autism Act 2009 and monitor the implementation of its provisions, statutory guidance and strategy. It was a highly effective body. Including a disability advisory board structure on the face of the Bill would entrench the board in the work of the commission, enabling a long-term and iterative structure in which disabled people could report on the reality of the impact of the Bill on disabled people across this country.

This reflects comments made by Dan Scorer of Mencap in oral evidence. He said that if the Bill was passed,

“We would want to see strong representation from patient groups...as well as from people who have been involved in the process, such as family members, advocates and clinicians, to make sure that if serious issues are being raised, they can be picked up early and addressed.”—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 30 January 2025; c. 280-81, Q367.]

The board must therefore consist of

- “(a) people who have a disability under the Equality Act 2010,
- (b) representatives from disabled people’s organisations, and
- (c) other such persons or organisations as the Commissioner considers relevant to the impact of the Act on disabled people.”

The commissioner would, within six months of being appointed, have to appoint a programme board to advise on the implementation of the Bill, and annually thereafter report on the impact of the Bill’s operation on disabled people.

The clause reflects the learning of Dr Greg Mewett, the specialist palliative care physician from Australia who gave oral evidence to the Committee about the Australian implementation taskforce, which includes a strong disability advocate. My new clause would go further, by including a rigorous reporting process that requires the advisory board to report to the Secretary of

[Dr Tidball]

State and the commissioner within six months of the commissioner being appointed, and annually thereafter. It also provides:

“The Secretary of State must, within three months of receipt of any report under subsection (3), lay the report before both Houses of Parliament.”

In the oral evidence sessions, I asked witnesses for their views on what structures or mechanisms could work to facilitate the opportunity to hear the voices of disabled people in monitoring the implementation and impact of the Bill were it to pass through Parliament. Dr Miro Griffiths said:

“I think there needs to be further robust action around how to collect data and allow it to be analysed, to see the trends that are occurring in why people are pursuing this option and how that may play into broader political and socioeconomic issues, such as a lack of services elsewhere or frustrations for disabled people and their families in trying to access particular services...I would therefore encourage their representation on any form of advisory council. I would also request that disability studies scholars, who are often left out of the discourse around disability policy, are part of any form of mechanism to advise or scrutinise.”—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 29 January 2025; c. 145, Q183.]

Subsection (2)(b) and (c) would provide for this.

Professor Tom Shakespeare corroborated the benefits of such an advisory board, calling it a “very good idea.” Importantly, Fazilet Hadi, from Disability Rights UK, stated:

“Should the Bill go through, it would be good to see a monitoring mechanism. I cannot say what that should be, but it would be good to see disabled people shape it. Some 45% of older people are disabled people, so disabled people are going to be very affected by the Bill.”

Poignantly, she went on:

“It is often our experience that we are the last people who are spoken to; maybe that is what is behind the question. We should of course be at the table now in respect of whatever mechanisms, and in the shaping of any implementation, should the Bill be passed.”—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 29 January 2025; c. 175, Q227.]

There is, and there should be, nothing about us without us.

As a disabled Member of Parliament, I am grateful to my hon. Friend the Member for Spen Valley for inviting me to sit on this Committee. Through this new clause and my earlier new clause 25, I have worked hard to put together a structure that ensures that disabled people are firmly at the table in the process of monitoring the implementation and impact of the Bill. I urge members of the Committee to support new clause 35.

**Jack Abbott:** At this point, I pay tribute to my hon. Friends the Members for Penistone and Stocksbridge and for Bexleyheath and Crayford. They have consistently tabled really important amendments that are very close to my heart, measurably improving the Bill.

I am briefly speaking in favour of new clause 35. We have had a number of good amendments about ensuring proper representation for vulnerable people during the process. We have also had a lot of discussion about the very important need to regularly monitor and report back on the Bill. This new clause brings all this together, ensuring that there is real oversight, with real thrust and a point to it. It is not good enough just to report back some statistics; the question is what we do with them.

Having this sort of panel, with expertise and life experience, would be a significant step forward for people with disabilities, learning needs and anything else that might be included.

Once again, I pay tribute to my hon. Friends for this work. I am fully supportive of the new clause.

**Sarah Sackman:** I hope to be brief, given it is the witching hour.

This new clause would require the voluntary assisted dying commissioner to establish within six months of their appointment a disability advisory board. The advisory board must include representation from disabled people and disabled people’s organisations. Within six months of its appointment, the advisory board must report to the Secretary of State and the commissioner to advise on the implementation of the Act for disabled people. We anticipate that the advisory board’s annual report will be separate from the commissioner’s, and that in time this may be subject to a level of integration between the two bodies. Practical arrangements for the advisory board would require further consideration, but the Government can see no workability reason why this should not go ahead.

12.15 am

**Kim Leadbeater:** I associate myself with the comments made by others, particularly my hon. Friend the Member for Ipswich, about the fantastic work done by my hon. Friends the Members for Penistone and Stocksbridge and for Bexleyheath and Crayford with regard to this new clause and other amendments. I also associate myself with the comments of the Minister for Care and the hon. Member for East Wiltshire about the fantastic work done throughout this Committee by our Chairs, the Clerks of the House and indeed all the staff of the House, and I pay tribute to colleagues who have served on this Committee; it has been hard work.

When I reflect on the criticism—sometimes, sadly, very personal—directed at me when we were putting the Committee together, I remember people saying that it would just be people who all agreed or people who would rush the Bill through. But here we are at this hour. I do not think this has been rushed through; I think we have taken an extremely thorough approach. “No amendments will be made” was the charge. We have made lots of amendments, and we will put the Bill back to the House in an even stronger position than it was in on Second Reading. I pay tribute to everybody involved in the process.

*Question put and agreed to.*

*New clause 35 accordingly read a Second time, and added to the Bill.*

*Schedules 1 to 6 disagreed to.*

## New Schedule 1

### THE VOLUNTARY ASSISTED DYING COMMISSIONER

“Status

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

- (3) The Commissioner's property is not to be regarded as property of, or property held on behalf of, the Crown.

*General powers*

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

*Deputy Commissioner*

- 3 (1) The Prime Minister must appoint a person to be the Deputy Voluntary Assisted Dying Commissioner (the 'Deputy Commissioner').
- (2) The person appointed must hold or have held office as a judge of—
- the Supreme Court,
  - the Court of Appeal, or
  - the High Court.
- (3) The Commissioner may delegate any of the Commissioner's functions to the Deputy Commissioner, to the extent and on the terms that the Commissioner determines.
- (4) The delegation of a function under sub-paragraph (3) does not prevent the Commissioner from exercising that function.
- (5) The functions of the Commissioner are to be carried out by the Deputy Commissioner if—
- there is a vacancy in the office of the Commissioner, or
  - the Commissioner is for any reason unable or unwilling to act.

*Appointment and tenure of office*

- 4 (1) A person holds and vacates office as the Commissioner or Deputy Commissioner in accordance with the terms and conditions of their appointment as determined by the Secretary of State, subject to the provisions of this paragraph.
- (2) An appointment as the Commissioner or Deputy Commissioner is to be for a term not exceeding five years.
- (3) A person may not be appointed as the Commissioner or Deputy Commissioner if a relevant appointment of them has been made on two occasions.
- 'Relevant appointment' here means appointment as the Commissioner or Deputy Commissioner.
- (4) The Commissioner or Deputy Commissioner may resign by giving written notice to the Secretary of State.
- (5) The Secretary of State may by notice in writing remove a person from the office of Commissioner or Deputy Commissioner if satisfied that the person—
- has behaved in a way that is not compatible with their continuing in office, or
  - is unfit, unable or unwilling to properly discharge their functions.

*Remuneration*

- 5 The Secretary of State may pay to, or in respect of, the person holding office as the Commissioner or Deputy Commissioner—
- remuneration;
  - allowances;
  - sums by way of or in respect of pensions.

*Staff: appointed by Commissioner*

- 6 (1) The Commissioner may appoint staff.
- (2) Staff are to be appointed on terms and conditions determined by the Commissioner.
- (3) The terms and conditions on which a member of staff is appointed may provide for the Commissioner to pay to or in respect of the member of staff—

- remuneration;
- allowances;
- sums by way of or in respect of pensions.

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

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

*Staff: secondment to Commissioner*

- 7 (1) The Commissioner may make arrangements for persons to be seconded to the Commissioner to serve as members of the Commissioner's staff.
- (2) The arrangements may include provision for payments by the Commissioner to the person with whom the arrangements are made or directly to seconded staff (or both).
- (3) A period of secondment to the Commissioner does not affect the continuity of a person's employment with the employer from whose service he or she is seconded.

*Staff: general*

- 8 (1) Before appointing staff under paragraph 6 or making arrangements under paragraph 7(1), the Commissioner must obtain the approval of the Secretary of State as to the Commissioner's policies on—
- the number of staff to be appointed or seconded;
  - payments to be made to or in respect of staff;
  - the terms and conditions on which staff are to be appointed or seconded.
- (2) A function of the Commissioner may be carried out by any of the Commissioner's staff to the extent authorised by the Commissioner (but this is subject to sub-paragraph (3)).
- (3) Sub-paragraph (2) does not apply in respect of—
- the Commissioner's function under paragraph 2(1) of Schedule (Assisted Dying Review Panels) of making appointments to the list of persons eligible to be panel members;
  - the Commissioner's function of determining applications for reconsideration under section (Reconsideration of panel decisions refusing certificate of eligibility).

*Financial and other assistance from the Secretary of State*

- 9 (1) The Secretary of State may—
- make payments to the Commissioner of such amounts as the Secretary of State considers appropriate;
  - give such financial assistance to the Commissioner as the Secretary of State considers appropriate.
- (2) The Secretary of State may—
- provide staff in accordance with arrangements made by the Secretary of State and the Commissioner under paragraph 7;
  - provide premises, facilities or other assistance to the Commissioner.

*Accounts*

- 10 (1) The Commissioner must—
- keep proper accounts and proper records in relation to them, and
  - prepare a statement of accounts in respect of each financial year in the form specified by the Secretary of State.
- (2) The Commissioner must send a copy of each statement of accounts to the Secretary of State and the Comptroller and Auditor General—

- (a) before the end of August next following the end of the financial year to which the statement relates, or
- (b) on or before such earlier date after the end of that year as the Treasury may direct.
- (3) The Comptroller and Auditor General must—
- (a) examine, certify and report on the statement of accounts, and
- (b) send a copy of the certified statement and the report to the Secretary of State.
- (4) The Secretary of State must lay before Parliament each document received under sub-paragraph (3)(b).
- (5) In this paragraph, “financial year” means—
- (a) the period beginning with the date on which the Commissioner is established and ending with the second 31 March following that date, and
- (b) each successive period of 12 months.

*Application of seal and proof of documents*

- 11 (1) The application of the Commissioner’s seal is to be authenticated by the signature of—
- (a) the Commissioner, or
- (b) a person who has been authorised by the Commissioner for that purpose (whether generally or specially).
- (2) A document purporting to be duly executed under the Commissioner’s seal or signed on the Commissioner’s behalf —
- (a) is to be received in evidence, and
- (b) is to be treated as duly executed or signed in that way, unless the contrary is shown.

*Public Records Act 1958*

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

*House of Commons Disqualification Act 1975*

- 13 In Part 3 of Schedule 1 to the House of Commons Disqualification Act 1975 (offices disqualifying person from membership of House of Commons), at the appropriate place insert—
- ‘The Voluntary Assisted Dying Commissioner or the Deputy Voluntary Assisted Dying Commissioner.’

*Freedom of Information Act 2000*

- 14 In Part 6 of Schedule 1 to the Freedom of Information Act 2000 (public authorities for the purposes of the Act), at the appropriate place insert—
- ‘The Voluntary Assisted Dying Commissioner.’

*Equality Act 2010*

- 15 In Part 1 of Schedule 19 to the Equality Act 2010 (public authorities subject to public sector equality duty), at the end of the group of entries for bodies whose functions relate to health, social care and social security insert—
- ‘The Voluntary Assisted Dying Commissioner.’—  
(*Kim Leadbeater.*)

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

*Brought up, and read the First time.*

*Question put, That the schedule be read a Second time.*

*The Committee divided: Ayes 15, Noes 8.*

**Division No. 108]**

**AYES**

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

**NOES**

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

*Question accordingly agreed to.*

*New schedule 1 read a Second time, and added to the Bill.*

**New Schedule 2**

**ASSISTED DYING REVIEW PANELS**

*“Introduction*

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

*List of persons eligible to be panel members*

- 2 (1) The Commissioner must make appointments to a list of persons eligible to sit as members of panels.
- (2) A person may be appointed to the list only if—
- (a) the person (a ‘legal member’)—
- (i) holds or has held high judicial office,
- (ii) is one of His Majesty’s Counsel, or
- (iii) has (at any time) been requested to act as a judge of the Court of Appeal or the High Court by virtue of section 9(1) of the Senior Courts Act 1981,
- (b) the person (a ‘psychiatrist member’) is—
- (i) a registered medical practitioner,
- (ii) a practising psychiatrist, and
- (iii) registered in one of the psychiatry specialisms in the Specialist Register kept by the General Medical Council, or
- (c) the person is registered as a social worker in a register maintained by Social Work England or Social Work Wales (a ‘social worker member’).
- (3) In this paragraph ‘high judicial office’ means office as—
- (a) a judge of the Supreme Court,
- (b) a judge of the Court of Appeal, or
- (c) a judge or deputy judge of the High Court.

*Tenure of persons appointed to list*

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

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

*Membership of panels*

- 4 (1) The Commissioner must make arrangements for determining the membership of a panel.
- (2) The arrangements must ensure that a panel consists of—
- a legal member,
  - a psychiatrist member, and
  - a social worker member.

*Decisions of panels*

- 5 (1) The legal member of a panel is to act as its chair.
- (2) Decisions of a panel may be taken by a majority vote; but this is subject to sub-paragraph (3).
- (3) The panel is to be treated as having decided to refuse to grant a certificate of eligibility if any member votes against a decision to grant such a certificate.

*Panel sittings*

- 6 (1) Panels are to determine referrals in public (but this is subject to sub-paragraph (2)).
- (2) The chair of a panel may, at the request of the person to whom a referral relates, decide that the panel is to sit in private.

*Staff and facilities*

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

*Practice and procedure*

- 8 (1) The Commissioner may give guidance about the practice and procedure of panels.
- (2) Panels must have regard to any such guidance in the exercise of their functions.

*Reasons*

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

*Money*

- 10 The Commissioner may pay to or in respect of members of panels—
- remuneration;
  - allowances;
  - sums by way of or in respect of pensions.

*House of Commons Disqualification Act 1975*

- 11 In Part 3 of Schedule 1 to the House of Commons Disqualification Act 1975 (offices disqualifying persons from membership of House of Commons), at the appropriate place insert—
- ‘Person on the list of those eligible for membership of an Assisted Dying Review Panel.’—(*Kim Leadbeater.*)

*This new Schedule contains provision about Assisted Dying Review Panels.*

*Brought up, and read the First time.*

*Question put, That the schedule be read a Second time.*

*The Committee divided: Ayes 16, Noes 7.*

**Division No. 109]****AYES**

Abbott, Jack	Gordon, Tom
Atkinson, Lewis	Green, Sarah
Charalambous, Bambos	Hopkins, Rachel

Joseph, Sojan  
Kinnock, Stephen  
Leadbeater, Kim  
Malthouse, rh Kit  
Opher, Dr Simon

Richards, Jake  
Sackman, Sarah  
Saville Roberts, rh Liz  
Shastri-Hurst, Dr Neil  
Tidball, Dr Marie

**NOES**

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

*Question accordingly agreed to.*

*Schedule read a Second time.*

*Amendment made to new schedule 2: (c), after paragraph 4(2) insert—*

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

*Amendment proposed to new schedule 2: (b), leave out paragraph 8(1) and (2) and insert—*

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

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

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

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

*Question put, That the amendment be made.*

*The Committee divided: Ayes 8, Noes 15.*

**Division No. 110]****AYES**

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

**NOES**

Abbott, Jack	Malthouse, rh Kit
Atkinson, Lewis	Opher, Dr Simon
Charalambous, Bambos	Richards, Jake
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 negated.*

*New schedule 2, as amended, added to the Bill.*

**The Chair:** Before I put the final question in Committee, I will make a brief statement about the arrangements for tabling amendments on Report. This information has been provided by email to members of the Committee and to others with an interest in the progress of the Bill, but I repeat it for the convenience of Members and any wider audience with an interest.

[The Chair]

The Public Bill Office will accept the tabling of amendments, new clauses and new schedules to the Bill by email only from the moment that the Committee reports until 10 am today, when they will accept tabling by all the usual methods—overnight by email, and from 10 o'clock in the morning, when the Table Office will be open. This means that Members may not come to the dais with tabling instructions once the Bill is reported. Members are strongly encouraged to wait for the publication of the Bill as amended in Committee before tabling amendments to the existing clauses and schedules, so that amendments reflect the changes made by the Committee. Anything sent to the Public Bill Office overnight will be dealt with by the staff in the morning.

I am strictly out of order, but may I add my thanks to the staff of the House and the Officers, the Doorkeepers, the *Hansard* writers and the Clerks, without whom our job—mine as Chair and yours as Committee members—would, frankly, be impossible? May I also thank all of you for, from what I understand from colleagues and certainly in my personal experience, what has been an extremely courteous discussion of a very difficult Bill? I congratulate you all, on whichever side of the fence you are, on the way in which this has been conducted. I am most grateful to you.

*Bill, as amended, to be reported.*

12.26 am

*Committee rose.*



**Written evidence reported to the House**

TIAB 435 Our Duty of Care

TIAB 436 Dr D. P. Whitehouse (further evidence)

TIAB 437 Dr Emma Boulton

TIAB 438 The Hon. Greg Donnelly MLC, Member of the New South Wales Legislative Council

TIAB 439 Welsh Language Commissioner

TIAB 440 Professor Jane L. Hutton (further evidence)

TIAB 441 Dr Mark Coley

TIAB 442 Dr Philip Howard (further evidence)

TIAB 443 Professor Kanch Sharma, consultant in neurology, neuropsychiatry and stroke





