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PARLIAMENTARY DEBATES

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Friday 29 November 2024

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The House met at half-past Nine o'clock

PRAYERS

[Mr Speaker *in the Chair*]

Rachel Hopkins (Luton South and South Bedfordshire) (Lab): I beg to move, That the House sit in private.

Question put forthwith (Standing Order No. 163) and negatived.

Terminally Ill Adults (End of Life) Bill

Second Reading

Mr Speaker: Before I begin proceedings, I would like to say a few words to help manage expectations about business today. More than 160 Members have indicated that they wish to speak in the first debate. It is not customary to impose a speech limit on private Members' Bills, but I hope that after the Member in charge of the Bill and the speaker after that, Members will restrict themselves to about eight minutes in the first instance; that includes taking interventions. The Chair will review the guidance as the debate progresses. I may need to ask for shorter speeches to enable more Members to contribute. I should make it clear that the Chair retains the right to impose a formal speech limit, but I would rather colleagues help each other.

At about 2 pm, I will call Front Benchers to make their comments, and then we will move to end the debate. I have got to manage expectations. Not everyone will get in. I will try to get in as many people as possible. This is one of the most important debates that the House has had, so it is about being considerate and respectful of each other. Let us listen to each other. This is the time for the House to show itself at its best.

The reasoned amendment in the name of Dr Ben Spencer has not been selected. I call Kim Leadbeater to move the Second Reading.

9.36 am

Kim Leadbeater (Spen Valley) (Lab): I beg to move, that the Bill be now read a Second time.

Thank you, Mr Speaker, and thank you to everyone who is attending this hugely significant debate. It is a privilege to open the debate on the Terminally Ill Adults (End of Life) Bill, a piece of legislation that would give dying people, under stringent criteria, choice, autonomy and dignity at the end of their lives. I welcome the debate on this hugely important issue.

Let me say to colleagues across the House, particularly new colleagues, that I know this is not easy—it certainly has not been easy for me—but if any of us wanted an easy life, I am afraid we are in the wrong place. It is our job to address complex issues and make difficult decisions. I know that for many people this is a very difficult decision, but our job is also to address the issues that matter to people. After nearly a decade since the subject was debated on the Floor of the House, many would say that the debate is long overdue.

For my part, I have tried incredibly hard to ensure that the tone of the debate has been—and continues to be—robust, of course, but most importantly respectful and compassionate. I am pleased that, for the most part, that has been the case. I can be confident that that same tone of respect and compassion will be adopted by colleagues today, whatever views they hold. That is particularly important as we have people in the Public Gallery who have a strong personal interest in this issue. They hold a range of views. Some of them have lost loved ones in difficult and traumatic circumstances, and others are themselves terminally ill.

I want to pay a huge and heartfelt tribute to those families and to every single person who has contacted me about this issue, and in many cases shared their own very personal stories of loss and death. I know from my own personal experience of grief that telling your story over and over again takes energy, courage and strength. I am incredibly grateful to them all. It is their voices and their stories that have inspired me.

Such stories are difficult to hear, but it is vital that they are heard as they are at the heart of the debate. They show that the law is failing people. Where that is the case, we have a duty to do what is right to fix it. Those here today or watching at home are dealing with the real consequences of the failings of the current system. I will start by recounting just a few of their stories.

Warwick was married to his wife Ann for nearly 40 years. She had terminal peritoneal cancer, which meant that she could not breathe properly. She spent four days gasping and choking, remaining awake throughout despite being given the maximum dose of sedatives. She eventually died of suffocation. She had begged Warwick to end her life, but as he stood over her with a pillow he could not do what she asked as he did not want that to be her final memory of him. Ann had excellent palliative care, but it simply could not ease her suffering.

Tim fell in love at first sight when he met his wife Louise—he proposed after just three days. But Louise got cancer, twice, and at the end, the morphine simply could not control her pain. In desperation, she managed to smash a small glass bottle and tried to take her own life, not realising that her toddler daughter had got into bed with her. Tim found her. He says,

> "You get to a point where you stop praying for a miracle and start praying for mercy."

Former police officer James waved is mum off as she embarked on her final trip, to Dignitas. She had terminal vasculitis. James desperately wanted to accompany his mum and hold her hand during her final moments, but he knew, because of his job as a police officer, that it was just not possible. Indeed, she insisted that he must not go with her, so she went alone—no one to hold her hand, and no proper goodbye or funeral. Those are just a few examples of the heartbreaking reality and human suffering that far too many people experience as a result of the status quo. the public know this.

I have always been keen to ensure that my politics stays rooted in the world beyond Westminster. It is clear that public opinion is very much in favour of a change in the law. Polling shows consistently that around 75% of people would like to see the legalisation of assisted dying for terminally ill, mentally competent adults. These findings are significant, but it may not be that

[Kim Leadbeater]

surprising that most people believe, as I do, that we should all have the right to make the choices and decisions we want about our own bodies. Let us be clear: we are not talking about a choice between life or death; we are talking about giving dying people a choice of how to die.

Let us examine what that choice currently looks like. I do not have a legal background but I have always been driven by a strong sense of injustice. If I see a problem, I will do everything I can to try to solve it. Indeed, in this job, we all do that every week and every day, whether here in Parliament or in our constituencies. When four former directors of public prosecutions, including the Prime Minister, two former presidents of the Supreme Court and many lawyers all agree that the law needs to change, surely we have a duty to do something about it.

Intentionally helping another person to end their life is currently illegal under the Suicide Act 1961, and carries a maximum prison sentence of 14 years. This includes family and friends helping someone who is terminally ill to die, both in the UK and overseas. Existing guidance does not stop people from being investigated by the police, adding fear, guilt and further trauma to grieving families. The law is not clear, and it does not protect individuals, families or medical professionals. That drives people to very desperate measures.

What about coercion? Senior King's Counsel have said:

> "There is currently no established system for identifying abuse or coercion in advance of a person's death or for helping vulnerable people to make end of life decisions."

Kevin McKenna (Sittingbourne and Sheppey) (Lab): I have been a nurse for more than a quarter of a century, and in that time I have worked mostly in intensive care as a specialist. I have worked with compassionate and skilled, well-trained clinicians who have been taught to spot coercion—it is fundamental to our practice. Does my hon. Friend agree that it is wrong to suggest that clinicians cannot spot coercion in these cases?

Kim Leadbeater: My hon. Friend makes a very important point. I thank him for it, and for his years of service as a nurse. I have spoken to many medical professionals about this issue, and they say that this is part of their job. They are very skilled and they work closely with patients, particularly dying patients, to assess their needs and to have those difficult and delicate conversations. As the KCs said, at the moment we check for coercion in cases where people have taken their own lives—when someone is dead. The Bill would make coercion a criminal offence with a sentence of up to 14 years.

Surely, by putting a legal framework around this difficult situation, we will provide an extra level of safeguarding. One psychotherapist, who is terminally ill herself, said to me recently that coercion happens when things are hidden away. The Bill would bring things out into the open. Surely, that must be safer for everyone. Let us look at what the absence of a robust legal framework looks like.

Simon Hoare (North Dorset) (Con): I thank the hon. Lady for giving the House the time to debate the Bill this morning. She references coercion, and I understand her point about the two medics, but medics will not be able to see or hear everything at all times. People will not be put beyond challenge, because subsequent to the death, if a relative claims coercion of another relative, investigation will remain. I am entirely unclear how, without peradventure, two clinicians can claim that there had been no coercion at any point.

Kim Leadbeater: The hon. Gentleman has made the point for me: within a robust system, we will check for coercion, but we do not have any of that now. At the moment, the person will be definitely be dead. We have to look at the status quo. Putting in layers of safeguarding and checking for coercion must be better than the system that we have now.

Alicia Kearns (Rutland and Stamford) (Con): Colleagues are right to raise questions around coercion. I hosted a phone-in on LBC where people rang in and said, "I feel like I have to end my life because I recognise how difficult it is for my family to see me suffering." The limit in the Bill, however, is that someone must have only six months to live according to two doctors and a judge, which I genuinely believe massively reduces the risk of coercion. Are we really saying that people are so desperate to bump off their families that if they were told that they had six months to live, they would escalate the process and do it sooner?

Kim Leadbeater: The hon. Lady makes an excellent point—she is absolutely right. The very strict criteria in the Bill add extra layers of safeguarding, which, again, we just do not have at the moment.

Richard Burgon (Leeds East) (Ind): I have the deepest respect for my hon. Friend, but one thing that concerns me is societal or systemic coercion. At the moment, elderly people in our society pay thousands of pounds a month to be in a care home. What reassurances can my hon. Friend give that an elderly person in a care home who has been given six months to live would not think to themselves, "I'm a burden. I have been given six months to live. If I end my life now, I can save my family between £25,000 and £55,000"? That really concerns me.

Kim Leadbeater: As I have said, at the moment, we have no idea whether that person would take action because we are not having those conversations. By getting two medical professionals and a High Court judge involved, we would be putting this out in the open. Evidence from other jurisdictions shows clearly that coercion tends to happen the other way; what tends to happen is that families try to prevent the person from making the choice of an assisted death.

Several hon. Members *rose*—

Kim Leadbeater: I will take one more intervention.

Wera Hobhouse (Bath) (LD): Is it not the case that the conversations that patients will have with doctors will bring out whether they have been coerced or are suffering intolerably? The criteria are about suffering, not whether somebody worries that they are a burden.

Kim Leadbeater: I agree absolutely. Those conversations, which are not taking place at the moment, are very important. I will make some progress.

There has rightly been a lot of discussion about palliative care in recent weeks, and I am convinced that a significant amount of that discussion would not have taken place without the introduction of the Bill. It is a long overdue conversation, and I am very pleased to see it happening.

I have met with the Association for Palliative Medicine, Hospice UK, Sue Ryder and Marie Curie, and last week I was delighted to attend the inaugural meeting of the all-party parliamentary group for hospices. I also attended the fantastic Kirkwood hospice, which serves my constituency of Spen Valley. I pay tribute to the dedicated staff and volunteers across the country in the palliative care sector, who do some of the most vital work in society. We must do more to support them, and I look forward to working with the Government and colleagues across the House in that important endeavour. That is why I have 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.

Of course, assisted dying is not a substitute for palliative care—it is not an either/or. We have some of the best palliative care in the world in this country, and, when it can meet the needs of terminally ill people, it is second to none. However, when it cannot, surely the choice of an assisted death should be one component of a holistic approach to end of life care.

The comprehensive report by the Health and Social Care Committee, published earlier this year, found no indications of palliative care deteriorating in quality or provision in places where assisted dying had been introduced.

Jim Shannon (Strangford) (DUP): Ever mindful of what the hon. Lady has said about the criteria, I remind her that Belgium started off with a simple project like the one she refers to but it deteriorated and expanded to include sufferers of dementia and under-18s—children. What guarantees do we have that this legislation will not end up with a situation like that in Belgium, in which case anything goes? Is that what the hon. Lady wants? I do not want that. Does she?

Kim Leadbeater: I thank the hon. Member for his intervention, but let us be very, very clear. Huge amounts of research has been done by the Health and Social Care Committee, and indeed by myself and others. The model being proposed here is nothing like what happens in Belgium. It is nothing like what happens in Canada. There are strict, stringent criteria, and if the House chooses to pass the Bill, those criteria cannot be changed.

Mark Pritchard (The Wrekin) (Con): I am grateful to the hon. Lady for giving way and congratulate her on the measured way in which she has conducted this debate over the last few weeks. Whatever side of the House and whatever side of the debate, I would like to recognise that—it is not always the case. But is it not the case that the Bill crosses a new and irreversible medical red line for doctors and nurses? Is it not the case that in other Bills we have seen in this House over the years, the safeguards invariably become obsolete over time, and so the safeguards in this Bill, however well meant, should be seen as temporary safeguards and not immutable safeguards?

Kim Leadbeater: Absolutely not. I respectfully disagree with the right hon. Gentleman. In countries where a Bill of this nature has been implemented, the safeguards have been in place and the boundaries have never changed. I will come on to talk about that.

Sir Oliver Dowden (Hertsmere) (Con) *rose—*

Kim Leadbeater: I will take one more intervention and then I must make some progress.

Sir Oliver Dowden: I thank the hon. Lady for giving way. I have a great deal of sympathy for the arguments she is making. However, we have seen, time and again, excessive judicial activism taking the words in this House and expanding their meaning into places we had not foreseen. What reassurances can she give that the words in her Bill will be respected by the judiciary and that we will not find ourselves in a decade's time in a totally different place that this House did not intend?

Kim Leadbeater: I thank the right hon. Gentleman for his intervention. The courts have repeatedly put this issue back to Parliament. This is not their domain. This is the legislation. There are strict criteria.

Coming back to palliative care, in situations where pain simply cannot be managed, the result is deaths that are so horrific that the person themselves can spend hours, and in some cases days, in unimaginable pain as they die. I want to bring the debate back to the issue that we are trying to solve. For their loved ones, no matter how many joyful and happy memories they have, they also have the trauma that comes from watching someone you love die in unbearable agony and fear. That memory stays with them forever.

Rebecca's mum Fiona developed metastatic brain cancer at the age of 69. She had very good palliative care, but her pain could not be managed, and she died begging and screaming for assistance to end her suffering. Her family and the medical team treating her cried beside her bedside as it took her 10 days to die.

Lucy's husband Tom was 47, a music teacher with a young son. He had bile duct cancer which obstructed his bowel, resulting in an agonising death. Tom vomited faecal matter for five hours before he ultimately inhaled the faeces and died. He was vomiting so violently that he could not be sedated and was conscious throughout. Lucy pleaded with the doctors to help. The doctor treating him said there was nothing he could do. His family say that the look of horror on his face as he died will never leave them. Lucy now has post-traumatic stress disorder, which is quite common for families who lose loved ones in such harrowing circumstances.

Rachel Taylor (North Warwickshire and Bedworth) (Lab): I thank my hon. Friend for the powerful and moving stories she is telling. A constituent of mine watched her mum suffer from pancreatic cancer. Unable to keep any food down, she basically starved to death. Does my hon. Friend agree that that is no way to see a loved one die? Does she also agree that we did not come into this place to shy away from difficult choices, but to listen to our constituents and make better laws for everyone?

Kim Leadbeater: I thank my hon. Friend for her intervention, and I am so sorry to hear that story from her constituency. We all have stories from all our constituencies, and she is absolutely right that we are here to make difficult decisions. On her example there, I have been astonished by the number of people who have been in touch with me to tell me about the terminally ill loved ones who have starved themselves to death out of desperation—something that takes far longer than we may imagine and is just horrific for everyone involved. That is currently legal, and doctors are required to assist the patient through this agonising process. How can we allow that, but not a compassionate and humane assisted death?

Blair McDougall (East Renfrewshire) (Lab): I join the right hon. Member for The Wrekin (Mark Pritchard) in commending my hon. Friend for the way she has made sure that this binary debate has not been a polarising one. I started the debate where she is now, but I have moved to opposing the Bill by the stories I have heard of disabled people who have had "do not resuscitate" put on their medical records without their permission, or who have been stopped by strangers in the street and been told, "You would be better off dead." I know she will say that we are voting on the specifics of her Bill, but we are also voting on a principle. Does she agree that there should be a precautionary approach, and does she honestly believe the legislative process gives us the time to be sure that we are making the right decision?

Kim Leadbeater: I thank my hon. Friend for his intervention and I will come on to some of those points later in my speech. Let us be very clear: the title of the Bill refers to terminally ill adults, not disabled people or elderly people, as another hon. Member referred to. The criteria are very clear.

I come back to the status quo, which is the problem we are trying to address. If people want to avoid the trauma of some of the harrowing circumstances I have described, they can have an assisted death—just not in this country. If they have £10,000 or £15,000, they can make the trip to Switzerland or elsewhere but, because of the current legal position, it is often a deeply distressing and very lonely experience, shrouded in secrecy, with people feeling like criminals as the fear of prosecution hangs over them.

Ilana's husband Crispin had late-stage motor neurone disease. He was paralysed, and Ilana is a wheelchair user, but at his request she took him on a traumatic and difficult journey to Switzerland. She describes the intense stress and anxiety she felt due to the total secrecy of their plan—and we can only imagine what the journey home was like, on her own, with an empty seat beside her.

There are also those terminally ill people who take matters into their own hands. Gareth's father Norman served in the Welsh Guards. He was a strong man, but his final five years were full of pain and discomfort. He had prostate cancer, which he lived with for 15 years. He was given good initial hormone therapy and chemo, but the cancer spread everywhere and the pain could not be eased. One day, when it all became too much, he went into his garden with the gun he owned and shot himself. Gareth's sister rushed to his house and found him. Gareth said his father just wanted the pain to stop.

Then there is Peter, from Mirfield in my own constituency, who stopped me in a car park a couple of weeks ago to tell me the harrowing story of his beloved wife, who was diagnosed with metastatic cancer aged 52. The treatment was ineffective and her symptoms were unbearable. She took an overdose of her medication, and Peter found her and took her to hospital. She recovered and he brought her home, but the following day she made another attempt to take her own life, in a way that is too awful to describe. Peter found her dead, and he spent the next eight hours being questioned by the police.

It is estimated that more than 600 terminally ill people take their own lives every year. Often patients will store up medication. Josh, a 33-year-old from Huddersfield went to coach his local kids' rugby team one Saturday and came back to tell his mum all about it. He found her dead. Lisa, who was terminally ill, had stored up her medication and taken her own life.

Our former colleague Paul Blomfield, the previous MP for Sheffield Central, has campaigned tirelessly on this issue since his dad Harry took his own life in 2014, alone in his garage, after being diagnosed with inoperable lung cancer. Language matters: Harry was not suicidal; he loved life, but he had watched too many of his friends have lingering, degrading deaths and he did not want that for himself. But, like the others, he could not tell Paul and his family of his plan, as they would have been complicit and could have faced prosecution. How many precious days and weeks did Harry miss out on as a result of having to take action while he was still physically able to do so? Hearing these stories is not easy, but it is important.

Lloyd Hatton (South Dorset) (Lab): What I have been struck by in recent weeks as I have listened to Members from across the House is the clear agreement that the current situation is neither sustainable nor dignified. Almost everyone in this House agrees that the status quo is unacceptable in terms of dignity, palliative care and end of life. Given that, does my hon. Friend agree that today's debate is about how we depart from the unacceptable situation that we currently face? Is today's vote not the first stage of an important discussion about we improve the end of life for hundreds and hundreds of people across this country?

Kim Leadbeater: I wholeheartedly agree. I am setting out what we are dealing with now. This cannot be right, and surely we have a duty to do something about it.

Wendy Morton (Aldridge-Brownhills) (Con): Will the hon. Lady give way?

Kim Leadbeater: I am going to make some progress, if that is okay.

Some of the most important voices in this debate are, of course, those of people currently living with a terminal illness. Having a terminal diagnosis is perhaps one of those situations where it is very hard, if not impossible, to know how we would feel. I have met many terminally ill people over recent weeks and every one of them is in my thoughts today.

Sophie, who is here today, was diagnosed with stage 4 secondary breast cancer, which has spread to her lungs, liver and pelvis. She is allergic to opioids, so she knows that her pain is very unlikely to be able to be managed.

She has a 17-year-old daughter. All she asks is to have the choice to say goodbye to her daughter at a time of her choosing, in circumstances that she can have some control over, and for her daughter to be able to remember her as the vibrant, positive woman she is.

Nathaniel, who also joins us today, has stage 4 incurable bowel cancer, which is now in his liver and brain. Like many of us, Nat says that he does not know whether he would choose an assisted death or not, but he simply cannot understand why anyone would want to deny him the choice. He says:

> "I wish to live as fully as I can and for as long as possible. But when the time comes",

Nat also wants

> "the right to die with dignity and compassion".

Another very emotional lady came up to me at a recent interfaith event. She and her husband thanked me for putting the Bill forward. She said, "Kim, I am a proud Christian and I am guided by my faith. But I also have terminal cancer and I want the right to choose a compassionate death."

There has been much discussion about the views of people who hold religious beliefs. I fully respect those beliefs and do not intend to say much more about this, other than that I know there are a range of views within faith communities. Indeed, some of the most powerful conversations that I have had have been with people of faith, including in my own constituency. People of different religions have said that although they would not choose an assisted death for themselves or their family, who are they to stop someone else who may want to make that choice?

Barry Gardiner (Brent West) (Lab): Will my hon. Friend give way?

Kim Leadbeater: I will make some progress, if I may. I hope that I have set out the problem that clearly exists. Now allow me to set out how the Bill can address that problem and, most importantly, do so safely and effectively.

If the Bill were to become law, it would contain the most robust and strongest set of safeguards and protections in the world. Very strict eligibility criteria and multiple layers of checks and safeguards are embedded in the Bill, none of which, as we have seen, exist at the moment. I made a conscious decision to name it the Terminally Ill Adults (End of Life) Bill, rather than anything else. That title can never be changed and ensures that only adults who were dying would ever come within its scope. As such, the Bill is not about people choosing between life and death; it is about giving dying people with six months or less to live autonomy about how they die and the choice to shorten their deaths.

The Bill does not apply to people with mental health conditions. It does not apply to the elderly. It does not apply to people with chronic health conditions, and it does not apply to disabled people, unless, of course, they have a terminal illness, in which case they would and should be entitled to the same rights as anyone else.

Daisy Cooper (St Albans) (LD): One group of people who are not often talked about are the learning disabled. Clause 9(3)(b) says that if an assessing doctor has any doubt as to the capacity of the person, they may refer them for a further psychiatric assessment. If the Bill is voted through today, will the hon. Member engage in a debate about whether that language should be strengthened from "may" to "must" and whether the training and experience required of the assessor should be strengthened as well?

Kim Leadbeater: The hon. Lady makes an excellent point and highlights a community who we must consider in light of the Bill. I would absolutely be open to that conversation in Committee; it is a very valid point.

There are different views within the disabled community. As Professor of Disability Research, Sir Tom Shakespeare says that it is unacceptable that people with disabilities continue to face social stigma and inequalities, but that it would be a mistake to conclude that we should oppose legalising assisted dying for terminally ill people until those wider problems are fixed. He says that it is paternalistic and wrong to imply that inequalities will be resolved by reducing choices, and that a clear, transparent legal framework for end-of-life choice is better for everyone. He is right. There is, of course, still work to do in the fight for equality for people with disabilities, but once again it is not an either/or. I will campaign alongside many others in this place for those rights, but I will also campaign for the rights of terminally ill people, because their rights are as important as anybody else's rights.

Barry Gardiner: I have huge respect for the hon. Lady for the way that she has conducted this debate over the last few weeks. My concern is that she has focused today on the individual and the individual choice, but we are here to legislate for society as a whole. In legislating, what we are saying if we pass the Bill is that it is okay to take that choice—*[Interruption]*—and there will be some people who have six months of their life to go who will then feel, "Ought I to do this? Is this something that I now should do?" That brings into play a whole set of considerations—"Is it better for my family? Is it financially better for my family?"—in ways that, at the moment, are out of scope. Rather than simply focusing on the individual suffering, which we all recognise is acute, we must broaden the debate to the impact that the legislation will have on society as a whole.

Kim Leadbeater: I thank my hon. Friend for his intervention. I suggest that the Bill will give society a much better approach towards end of life. We are already hearing conversations about dying and death which I do not think we have heard enough in this country. We have to take a holistic view. Indeed, that is what happens in other countries and other jurisdictions. Having those deep and meaningful conversations about death and dying is really important. My hon. Friend's comments bring me on nicely to the protections and safeguards in the Bill.

Mr Toby Perkins (Chesterfield) (Lab): A decade ago, I voted against a similar Bill, because I felt that perhaps it was not perfect and there were more things that I needed to know. My hon. Friend is right that we have not talked about death for the 10 years since or considered any legislation. The truth is that if we vote against her Bill today, it will be the end of the conversation once again for another decade.

Kim Leadbeater: My hon. Friend is absolutely right. How many people will go through the situations I have described if it is another 10 years before we address this matter?

Several hon. Members *rose—*

Kim Leadbeater: I am not going to take any more interventions, I am afraid, because I am conscious that lots of hon. Members want to speak; I know Mr Speaker is conscious of that as well.

Under the Bill, any terminally ill person who wants to be considered for an assisted death would have to undertake a thorough and robust process involving two doctors and a High Court judge. No other jurisdiction in the world has those layers of safeguarding. The person requesting assistance must have mental capacity and a settled wish at every stage. That means they must repeatedly demonstrate that they understand the information relevant to their decision, the ability to retain that information, and to use or weigh that information as part of the process of making the decision. We know that capacity can fluctuate which is why it is assessed at every step of the process.

Melanie Ward (Cowdenbeath and Kirkcaldy) (Lab): On that point, will my hon. Friend give way?

Kim Leadbeater: I am sorry but I am not going to take any interventions, as I need to make progress.

The court must speak to one of the doctors and can hear from anybody else they deem necessary. If there is any evidence of coercion, the court will not approve the request, and if evidence emerges subsequently, the court order could be revoked. It is also important to note that the person can change their mind at any time, with periods of reflection built in. Having consulted at the highest levels in the judiciary and the medical profession, I know that they can and will fulfil those safeguarding responsibilities and that they have the expertise to do so.[1]

Let us be clear: as my hon. Friend the Member for Sittingbourne and Sheppey (Kevin McKenna) said earlier, this is not brand new territory for doctors. Doctors, working in partnership with other clinicians, are already required to manage complexity in end-of-life decision making. I followed the request of the British Medical Association that doctors should be under no obligation whatsoever to participate, but if they do participate, they will receive appropriate training and support. Doctors should be able to use their professional judgment when and if a conversation takes place, taking their cue from the patient, as they do for many other issues. I welcome that patient-centred approach. Many doctors feel the change in the law would safeguard clinicians and patients by making everything explicit.

When it comes to the detail of what assisted dying would look like, we have the benefit of drawing on the experience of 31 jurisdictions around the world. I could talk extensively about the international experience of assisted dying. The Health and Social Care Committee report did a brilliant job of that, and this Bill has looked at best practice as well as models which I and many others would not be comfortable with our having here in England and Wales.

Reflecting on their experience, clinicians in Australia say:

> "through deep and meaningful conversations between doctors, patients and their loved ones we can dispel fear, reduce suffering, bring death and dying out of the shadows, and so allow patients and their families a better quality of life and quality of death".

As one Australian Member of Parliament said:

> "We have brought 'behind-closed-doors' practices into the open and given dying people meaningful, transparent choices. Crucially none of the fears that were put forward as reasons not to change the law have been realised. The status quo was broken and assisted dying works."

Evidence from around the world shows that the option of having an assisted death actually lifts the fear that terminally ill people have, and that many never actually use it but are able to make the best of the time they have left due to the comfort and reassurance that it provides.

People talk about a slippery slope, but the Health and Social Care Committee found that not one jurisdiction that has passed laws on the basis of terminal illness has expanded its scope. *[Interruption.]* That is absolutely true. As the courts here and in Europe have repeatedly made clear, Parliament is sovereign. This Bill could not be made any broader through any judicial process.

Speaking of process, with reference to the Bill, having listened to what I know are genuine concerns of Members about ensuring that we get this legislation right, I commit to the House that if the Bill passes Second Reading today, which I sincerely hope it does, I am minded to move a motion that gives the Bill Committee the power to take oral and written evidence in order to ensure that a thorough approach continues to be taken. That is not normal procedure for a private Member's Bill, but I think that that is the right thing to do. I also reassure colleagues that the Bill Committee will meet over a number of weeks, meaning that there is ample time for full consideration of the details of the Bill, including amendments. The Committee will be representative of the views and make-up of the House. Let me be clear: that will mean there will be representatives of different parties with a range of views on the Committee.

As the Leader of the House said at the Dispatch Box just yesterday, and has said several times, the Government will, of course, work with me to ensure that the Bill is workable and operable. That will quite rightly take time, and I have included in the Bill a commencement period of up to two years—this is not going to happen overnight. That timeframe can be explored in Committee, as it is more important to get this right than to do it quickly.

In conclusion, for the reasons I have set out, I am very clear that the law needs to change to give terminally ill people choice at the end of life and to protect their loved ones from fear of prosecution. There will be some of us here today who are lucky enough not to have personal experience of this issue, but sadly we know that any one of us could end up in this heartbreaking situation. We are all living longer, which is brilliant, and I have campaigned inside and outside Parliament for a greater focus on prevention and early intervention of illness and disease to keep us fit and healthy for as long as possible, but any one of us or our loved ones could be unfortunate or unlucky enough to receive a terminal diagnosis. I struggle to see how it is fair or just to deny anyone the autonomy, dignity and personal choice of taking control of their final weeks. And the right to choose does not take away the right not to choose.

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[1] [*Official Report*, 29 November 2024; Vol. 757, c. 1079.] (Correction)

Giving the choice of an assisted death to those who want it would of course not stop anyone who is terminally ill from choosing not to make that choice.

Whatever happens today, I am incredibly proud of the work that my fantastic team and the many campaigners have done on this hugely significant, emotional and sensitive subject. We need to be clear: a vote to take this Bill forward today is not a vote to implement the law tomorrow. It is a vote to continue the debate. It is a vote to subject the Bill to line-by-line scrutiny in Committee, on Report and on Third Reading. Then, of course, the Bill will go to the Lords for what I have no doubt will be further robust debate and scrutiny. This will be a thorough process, focused on one of the most significant issues of our time—an issue that people across the country clearly want us to address, none more so than the many families who are facing the brutal and cruel reality of the status quo. Today is the beginning, not the end, of that process, but the debate can continue only if colleagues join me in the Aye lobby today. I wholeheartedly encourage them to do so, and I commend the Bill to the House.

10.15 am

Danny Kruger (East Wiltshire) (Con): I think you indicated that I could speak for a little longer than eight minutes, Mr Speaker.

Mr Speaker: Yes.

Danny Kruger: Thank you very much. I do not want to have too much grumbling at the eight-minute moment. I will take my 15 minutes, with time for interventions.

I start by paying tribute to the hon. Member for Spen Valley (Kim Leadbeater) for her very powerful speech and the way in which she has led this campaign—with great respect, sensitivity and, to use a contested word, dignity. She and I knew each other before we were MPs, when we both worked in the charity sector. I like and admire her greatly, and I know that we have more in common than might appear today.

All of us in this House have this in common: we all share a deep concern about the experience of people dying or fearing death, pain and suffering. I bear heavily on my conscience the people whose lives will be prolonged beyond their wishes if I get my way and this Bill is defeated today. I will not disregard those people or minimise their anxiety. We will hear those voices in today's debate—we have heard many of them already—speaking through hon. Members in what I know will be very moving speeches.

If I voted for this Bill, I would have on my conscience many more people whose voices we cannot hear—the people who would be vulnerable as a consequence of the huge changes that this Bill would introduce in our society and in the NHS. My view is that if we get our broken palliative care system right and our wonderful hospices properly funded, we can do so much more for all the people who we will hear about today, using modern pain relief and therapies to help everybody die with a minimum of suffering when the time comes. We will not be able to do that if we introduce this new option; instead, we will expose many more people to harm.

I will go through the Bill in a moment, but first I will say a word about process, in response to the points made by the hon. Member for Spen Valley. This Bill is simply too big for the time that it has been given, and I implore hon. Members not to hide behind the fiction that it can be amended substantially in Committee and in its later stages. The remaining stages of a private Member's Bill are for minor tweaks, not the kind of wholesale restructuring that we would need if we were ever to make this Bill safe. Members who vote for the Bill today must be prepared to see it become law largely unamended. I suggest that if they have any doubts, the only responsible choice is to vote no, and let the advocates of assisted dying bring back a better Bill at another time.

Alistair Strathern (Hitchin) (Lab): I deeply appreciate the respectful way in which the hon. Gentleman is making his point, but I stand before him not sure of how any colleague in this Chamber cannot have doubts whichever way they are voting today. It feels like there are two necessary harms that we are all forced to weigh up. If the hon. Gentleman is so certain that doubt should push people one way, I am deeply intrigued to hear why that is, when it is very clear that many people will continue to suffer unnecessarily if we reject this Bill.

Danny Kruger: I recognise that there are very many doubts on each side, and I fully respect the arguments that have been made by the hon. Member for Spen Valley. Of course this is a finely balanced debate, but the point about process is that this Bill is too flawed; there is too much to do to it to address in Committee. By all means, let us have this debate, but let us have that before a Bill of this magnitude is brought forward, The consideration of the Bill should be much more comprehensive.

Andrew George (St Ives) (LD): Contrary to what the media are saying, today's decision is not about bringing this Bill into law; it is about allowing it to go to the next stage. People may have misgivings, but the hon. Gentleman is making the assumption that the Bill cannot be corrected or amended in order to make it palatable to people who have doubts. We all have doubts, but surely today's vote is simply to let it go to the next stage. The final decision on Third Reading is the critical one in deciding whether the Bill goes into law.

Danny Kruger: I think I have made the point that this Bill is too comprehensive and there is too much in it to address through the process of a private Member's Bill. If the hon. Gentleman has serious concerns about aspects of the Bill that he would not be prepared to see come into law, he should not be supporting it today.

Let me explain the concerns about the Bill that I think are too comprehensive to be dealt with in Committee. I recognise how hard the hon. Member for Spen Valley has worked to try to ensure that it is safe, but I do not believe it is, for the following reasons. Let us start at the beginning. The process starts with a conversation between a patient and a medical practitioner—not necessarily a doctor; just a medic of some sort, unspecified at this stage. If the patient tells their ordinary family doctor that they want an assisted death, the doctor is obliged to either explain how it works or pass them on to someone who will do it—which is probably what will happen, by the way. The likelihood is that we would see a new branch of medicine spring up, like the medics I met in Canada.

Kevin McKenna: Will the hon. Member give way?

Danny Kruger: I will in a moment.

These medics I met in Canada are specialists in assisted death and personally kill hundreds of patients a year in their special clinics. *[Interruption.]* If hon. Members have difficulty with the language, then I wonder what they are doing here. This is what we are talking about. I met doctors for whom this is their profession and their job, and they are proud to do it.

Lewis Atkinson (Sunderland Central) (Lab): Will the hon. Member give way?

Danny Kruger: I will give way to the other hon. Gentleman.

Kevin McKenna: I want to be very clear that "medical practitioner" is a synonym for doctor—not nurse, pharmacist, dentist or any other practitioner. To be a doctor is to be a practitioner of medicine. We need to be very clear on this. There is lots of law and regulation on this, and I believe that what the hon. Member said is incorrect.

Danny Kruger: What the Bill actually says is that a doctor means

> "a registered medical practitioner…who has such training, qualifications and experience as the Secretary of State may specify by regulations".

Obviously they are some sort of regulated medic—I recognise that—but they are not necessarily a doctor. We will find out. I recognise that they will have professional qualifications, but it is not clear what those are going to be because it is not in the Bill.

Gavin Robinson (Belfast East) (DUP): I commend the hon. Gentleman for the way in which he is engaging in this discussion, in the same spirit as the hon. Member for Spen Valley (Kim Leadbeater). We often hear that one of the safeguards associated with the Bill is that medical practitioners would be involved and that a diagnosis of a terminal illness, with six months or less to live, would be required. Does the hon. Gentleman accept that medicine is not an exact science? It is the science of uncertainty blended with the art of probability. There is no exactitude in this. No court will second-guess medical opinion; it will simply look at process.

Danny Kruger: I entirely agree with the right hon. Gentleman; he is absolutely right. I am afraid that the definition of terminal illness is in a sense the essential flaw in the Bill, but I will come on to that.

Going back to the conversation that the patient has with the medical practitioner, the crucial point is that the conversation does not need to be started by the patient, according to the Bill. It could be started by the medic—any medic—perhaps in hospital, who could make the suggestion of an assisted death to a patient who has never raised the issue themselves, whose family have never suggested it and whose own doctor does not think it is the right thing to do. And so the idea is planted.

Then, for whatever reason—and, by the way, there is no need ever to give a reason—the patient says that they want to proceed with an assisted death. They sign a declaration, or rather somebody else can sign it for them. It could be any professional, someone they do not know—maybe a new medical practitioner. A total stranger can do all the paperwork on their behalf. That is what the clause about the proxy entails. Then these two medical practitioners make their assessment.

Paula Barker (Liverpool Wavertree) (Lab): I urge the hon. Member to check the wording of the Bill, because if somebody signs as a proxy, they have to have known the individual for two years, and would simply be signing to say that they agree with the patient who wishes to go forward with assisted dying.

Danny Kruger: I do not have time to check the Bill now, but from my memory it refers to someone who has known the patient for two years or someone of good standing in the community, which could be some sort of professional who is not known to them at all. Someone can quickly check the Bill, but my understanding is that it could be a total stranger to them.

Jim Allister (North Antrim) (TUV): Is the matter not very clear? Clause 15(5) states:

> "In this section "proxy" means—
>
> (a) a person who has known the person making the declaration personally for at least 2 years, or
>
> (b) a person who is of good standing in the community."

So there is no protection such as that which is pretended by the supporters of the Bill.

Danny Kruger: I am grateful for that intervention.

The assessments have to determine whether the patient is terminally ill, whether they have mental capacity to make the decision, and then whether they have been coerced or pressured into the decision. In many ways the whole issue turns on the question of whether someone is terminally ill. I am afraid that it is a term of great elasticity, almost to the point of meaninglessness. It is well known, as the right hon. Member for Belfast East (Gavin Robinson) said earlier, that it is impossible for doctors to predict with any accuracy that somebody will die within six months. It is a purely subjective judgment, made in this case by a doctor whose job will be approving assisted deaths. They simply have to determine not whether it is reasonably certain that death will occur, but that it can be reasonably expected—in other words, that it is possible.

Simon Hoare: The thrust of the Bill, as I understand it, is to ease suffering and pain in a patient who has a diagnosis and will die of the condition that has been diagnosed. But that right could only be exercised within a six-month period, and the pain and discomfort could last a lot longer than that. Has my hon. Friend heard—because I have not—what the importance of six months is? Why not eight, 10 or 12? What would stop people challenging it on the grounds that the dam has been breached, the six months is entirely arbitrary and it could, and indeed should, be extended by negative resolution in a statutory instrument?

Danny Kruger: My hon. Friend makes the right point, and I am afraid to say that is absolutely the case. The six-month cut-off is completely arbitrary and impossible to determine. It is a line in the sand, and of course it could be challenged, as so much of the Bill could be challenged, on human rights grounds. Every one of the safeguards that has been introduced by the hon. Member for Spen Valley would in fact be a barrier and a discrimination against the new human right that has been awarded to one group but should of course be awarded to all—if the point is conceded in this way.

Melanie Ward: Earlier this week, colleagues and I met two eminent doctors who were former presidents of the Association for Palliative Medicine, and they raised serious concerns about the Bill, including that the doctor or medical practitioner who makes the assessment need never have met the person they are assessing, or been involved in their care at all. What does the hon. Gentleman make of that?

Danny Kruger: The hon. Lady makes a very important point. I will not get into the question of public opinion and the polling, because it is so contested, but there is clear evidence that the doctors who work with the dying—the palliative care professionals—are opposed to a change in the law by a great majority. They see the damage that it would do to the palliative care profession and services, and they see the danger for vulnerable patients.

Wera Hobhouse: I appreciate that the hon. Gentleman talks to us as a medical professional and we need to listen to his views. But is it not true that any medical assessment is an approximation; something that cannot be said for certain? For this decision too, we cannot be 100% certain, but that is life. We cannot make legislation that is 100% good because at some point we have to make a decision, on balance, whether something has merit or not. For that reason, we should vote for the Bill.

Danny Kruger: I am grateful to the hon. Lady, especially for promoting me to the status of doctor; I am actually a charity worker and political hack by background. It is good of her to credit me with those skills—perhaps I should set myself up as a medical practitioner. She is right that medics and indeed judges have to make difficult judgments all the time. I think it would be very dangerous and inappropriate to give them the power to do so in this case.

The whole question of the six-month cut-off is very important. I acknowledge all the points that have been made, but there is another problem with the definition of terminal illness. Almost anybody with a serious illness or disability could fit the definition. I recognise that these are not the cases that the hon. Member for Spen Valley has in mind—of course they are not—but that is the problem with the Bill. All that someone needs to do to qualify for an assisted death—for the definition of terminal illness—is refuse treatment, such as insulin if the person is diabetic. In the case of eating disorders, a topic on which I have worked with the hon. Member for Bath (Wera Hobhouse), a person just needs to refuse food. The evidence from jurisdictions around the world, and our own jurisprudence, shows that that would be enough to qualify someone for an assisted death.

Lewis Atkinson: Does the hon. Gentleman accept that every day in the NHS patients refuse treatment, and indeed food, and that there is currently legal oversight in respect of coercion and other such matters? Would the Bill not strengthen protections in those areas?

Danny Kruger: I am perplexed by that argument. The suggestion that there may be coercion—of course there will be—and abuse, and all sorts of injustices that take place in the current system, does not strike me as an argument for regulating and licensing assisted suicide. If we have concerns about practice in the NHS, let us deal with that. Let us not license suicide—and, by the way, evidence from around the world shows that that increases suicide in the general population. Suicide is contagious. For instance, Oregon is often pointed to as an example. The incidence of suicide, outside assisted suicide laws, has risen by a third there since it was legalised. There would be enormous contagious effects were we to regulate and license it in this way.

Richard Tice (Boston and Skegness) (Reform): The hon. Gentleman is making an excellent case for the Bill to be passed today. What he is actually saying is that there are specifics that require debate, analysis and discussion in great detail in Committee—that is the whole point of it. If it is not dealt with properly in Committee, it will not pass Third Reading. He is suggesting that because he does not like those specifics, we cannot discuss the Bill in any detail.

Danny Kruger: I am sure that the hon. Member for Spen Valley is delighted to have the support of the hon. Gentleman. I refer him to the point that I was making: this is an inappropriate process.

Sir John Hayes (South Holland and The Deepings) (Con): My hon. Friend is making a superb speech, as I expected him to do. On the issue of process, I say this to the hon. Member for Boston and Skegness (Richard Tice), my constituency neighbour: as he will know, I have introduced some very serious Bills, including the one that became the Investigatory Powers Act 2016. It was preceded by three independent reports and pre-legislative cross-party scrutiny by both Houses, which happened before the Committee stage. The point is that that process should take place before Second Reading, not after.

Danny Kruger: I am grateful to my right hon. Friend. I will now run through the process before taking any more interventions.

As I have explained, pretty much anybody with a serious illness or disability could work out how to qualify for an assisted death under the Bill. Members may think that far-fetched, but it is what happens everywhere that assisted suicide is legal, including in Oregon.

Cat Eccles (Stourbridge) (Lab): On a point of order, Mr Speaker. The hon. Gentleman is using incorrect language. It is not suicide. That is offensive. I ask him please to correct his language.

Mr Speaker: That is not a point of order.

Danny Kruger: I am sorry if offence is given, but the fact is that the value of having a Bill in black and white is seeing what the law really is. What the Bill would do is amend the Suicide Act 1961. It would allow people to assist with a suicide for the first time. I respect the hon. Lady's concern, but I am afraid we do need to use the proper language here.

[Danny Kruger]

The Bill's scope is very broad. Members who think that assisted suicide for people with anorexia or other conditions that would not be regarded as terminal could not happen here should consider the young people in the UK today who are given a diagnosis of terminal anorexia and put on a palliative care pathway—essentially, assigned to death. Of course these are extreme cases—

Wera Hobhouse *rose—*

Danny Kruger: I am not going to give way again.

There are a great many of these cases, I am afraid, and I mention them to show how wide open the Bill is. *[Interruption.]*

Mr Speaker: Order. May I ask the hon. Member for Bath (Wera Hobhouse) to keep a little calmer? She has intervened twice already, and plenty of other Members who also need to be heard.

Danny Kruger: I think particularly of disabled people, many of whom require constant treatment to stay alive. All, immediately and by definition, will be eligible under the terms of the Bill for a state-sponsored death. I refer Members to the Equality and Human Rights Commission, which has made the point that the line between disability and terminal illness is very blurred. That is why the Bill's title is, in fact, so dangerous.

Mary Kelly Foy (City of Durham) (Lab) *rose—*

Danny Kruger: I will make a little progress.

The second question that medical practitioners have to answer is about mental capacity, and here again is a great vagueness. How do they judge if someone is in their right mind when they are asking for help to kill themselves? The Bill says that the definition of capacity is based on the Mental Capacity Act 2005, but that Act is deliberately expansive. It explicitly assumes capacity in the patient, so having acute depression is no bar to being judged to have capacity under the Act. Being suicidal is no bar under the Act, so the capacity test is no bar at all.

Finally, there is the question of coercion. Is the patient asking for an assisted death because of pressure from someone else? There are two glaring problems here. The first is that the process does not even attempt to answer the question properly. There is no investigation, no requirement for medics to interview friends and family, and no need for a psychiatrist or family doctor to be consulted. The medics just need to satisfy themselves—who knows how?—that, to the best of their knowledge, the person has not been pressured.

The second problem with the coercion test is that it focuses on only one type of coercion—the less likely type. The bigger danger is not other people pressuring someone to do this; it is that they pressure themselves—hon. Members have made this point. The Bill has nothing to say on that. Internal pressure is absolutely fine. If you feel worthless or a burden to others, if the NHS will not offer you the treatment you need, if the local authority will not make the adjustments you need to your home, if you have to wait too long for a hospital appointment, or if you want to die because you think the system has failed you, that is absolutely fine.

Several hon. Members *rose—*

Danny Kruger: I will get to the end of my speech.

That is the medical stage, and I will jump straight to the judicial stage. The medical practitioners sign it off, and then the judge has to confirm all the same tests. Of course, many eminent judges have made the point that it will overwhelm the family courts if the test were applied properly, but it will not be applied properly, because the Bill assumes that judges will fulfil a new inquisitorial role and actually look into cases as investigators, which is entirely unknown in English common law. But the Bill will not require any actual investigation.

There is no requirement for a judge even to meet the applicant. They simply have to have a phone call, or maybe it will be an email, from one of the medics. That is it. That is the inquiry. On that basis, the judge must decide whether it is more likely than not that there has been external pressure. After the judge approves it—they are required to approve it, unless they can find evidence of external coercion—we go to "the final act", as the Bill says, where a junior colleague, as a medical practitioner, oversees your death by pills or lethal injection.

And here is the last thing that the Bill does or does not do. There is no requirement at any stage of the process—at either the medical or the judicial stage—for anyone to tell the patient's next of kin, their wider family or even their GP that the NHS and the judicial system are working in secret to bring about the death of their loved one, maybe their father or their daughter. I say again that these are not the cases that the Bill was designed for, but they are directly in scope, and it is going to take more than a tweak in Committee to get them out.

Is this what is meant by having choice at the end of life? Let us talk about choice. I am often accused of wanting to impose my view on others—that point was made earlier. People say, "If you don't approve of assisted death, don't have one, but don't deprive me of the choice." In fact, the evidence is that, with this new option and the comparative loss of investment and innovation in palliative care, real choice will narrow. There is a broader point to make about choice, which is that no man or woman is an island. Just as every person's death, even a good death, diminishes us all, so we will all be involved and affected if we make this change.

The Bill will not just create a new option for a few and leave everyone else unaffected; it will impose this new reality on every person towards the end of their life, on everyone who could be thought to be near death, and on their families—the option of assisted suicide, the obligation to have a conversation around the bedside or whispered in the corridor, "Is it time?" It will change life and death for everyone.

I am very aware of the terrible plight of the people who are begging us for this new law. I think we can do better for them than they fear, but we also need to think in real human terms about what the effect will be on the choices of other people, and I do not mean the people who are used to getting their way. I am talking about the people who lack agency, the people who know what it is to be excluded from power and to have decisions made for them by bigwigs in distant offices who speak a language they do not understand—the sort of people who the hon. Member for Spen Valley and I both know from our previous charity work, and who we all know from our constituency work. They are not the people who write to us campaigning for a change in the law, but the people who come to our surgeries with their lives in tatters, or who the police or social workers tell us about—the people with complex needs. What are the safeguards for them?

Let me tell the House: we are the safeguard—this place; this Parliament; you and me. We are the people who protect the most vulnerable in society from harm, yet we stand on the brink of abandoning that role. The Rubicon was a very small stream, but on the other side lies a very different world—a worse world, with a very different idea of human value. The idea that our individual worth lies in our utility, valuable only for so long as we are useful—not a burden, not a cost, not making a mess. Let us not be the Parliament that authorises that idea.

I mentioned at the start of my speech the voices of those we cannot hear: the frail and elderly and the disabled. As we are surrounded by such a cloud of witnesses, let us do better than this Bill. Let today be not a vote for despair, but the start of a proper debate about dying well, in which we have a better idea than a state suicide service. Let us have a debate in which we remember that we have intrinsic value; that real choice and autonomy means having access to the best care possible and the fullest control over what happens to us while we live; and that true dignity consists in being cared for to the end.

Several hon. Members *rose*—

Mr Speaker: Order. I remind the House that we want to aim for speeches of up to eight minutes. I call the Mother of the House.

10.40 am

Ms Diane Abbott (Hackney North and Stoke Newington) (Lab): I congratulate my hon. Friend the Member for Spen Valley (Kim Leadbeater) on bringing forward this Bill, which has been the occasion of a very important national conversation. I recall to the House the fact that, in 1969, Parliament voted to abolish the death penalty for murder. Public opinion was actually against that change, but MPs believed, on a point of principle, that the state should not be involved in taking a life. It was a good principle in 1969 and it remains a good principle today.

I am not against legalising assisted dying in any circumstance, but I have many reservations about this Bill. In particular, I do not believe that the safeguards are sufficient. They are supposed to be the strongest in the world because of the involvement of a High Court judge, but the divisional courts have said that

> "the intervention of a court would simply interpose an expensive and time-consuming forensic procedure".

Sir James Munby, the former president of the family division of the High Court, said recently:

> "Only those who believe implicitly in judicial omniscience and infallibility—and I do not—can possibly have any confidence in the efficacy of what is proposed."

Is the judge supposed to second-guess doctors? Will the judge make a decision on the basis of paperwork? Or will there be a hearing in open court? Where will be the capacity in the criminal justice system to deal with all this? Far from being a genuine safeguard, the involvement of a judge could just be a rubber stamp.

Catherine Atkinson (Derby North) (Lab): More than two thirds of care proceedings involving the most vulnerable children in our society cannot be completed within six months. Does my right hon. Friend agree that there is a real concern that the safeguard is not deliverable, or risks being the rubber stamp that I know my hon. Friend the Member for Spen Valley (Kim Leadbeater) does not want it to be?

Ms Abbott: I entirely agree with my hon. Friend.

Robust safeguards for the sick and dying are vital to protect them from predatory relatives, to protect them from the state and, above all, to protect them from themselves. There will be those who say to themselves that they do not want to be a burden; I can imagine myself saying that in particular circumstances. Others will worry about assets they had hoped to leave for their grandchildren being eroded by the cost of care. There will even be a handful who will think they should not be taking up a hospital bed.

Jake Richards (Rother Valley) (Lab): My right hon. Friend makes her case powerfully. Can I ask her to comment on the current situation whereby people ask themselves the question she just asked today? What safeguards are there for those people? What inquiry is made before those people pass away, often having taken the most drastic and horrific action to do so?

Ms Abbott: But if the House passes this legislation, the issue that I have raised will become foremost in people's minds even more so.

We are told that there is no evidence of coercion in jurisdictions where assisted suicide is possible, but 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.

Shockat Adam (Leicester South) (Ind): As a medical professional who is surrounded by even more senior medical professionals, I know we can all miss things when there are tangibles in front of us: the shadows on X-rays and the markers on blood tests. As professionals, we miss things that can be seen. What security will we have that we can pick up things that we cannot see, like coercion?

Ms Abbott: That is the point: coercion is something that there will be no material evidence of and that we cannot see.

People keep saying that the Bill cannot be amended, but of course any future Government could bring in new clauses. We can see what has happened in Canada, which introduced assisted dying in 2016 for adults with terminal illnesses. In 2021, it was extended to people with no terminal illness and the disabled. In March 2027, anyone with a serious mental health problem will also be eligible. The House should remember that no single organisation representing the disabled supports the Bill.

Mary Kelly Foy: My daughter Maria lived her life with severe disabilities and health conditions. Since her birth, we were told many times that she might have only six months to live. She lived for 27 years. Crucially, Maria was non-verbal. I am filled with dread and fear about what might happen to people like Maria who are non-verbal and do not have that capacity, if they are not loved and cared for and do not have somebody speaking out for them.

Ms Abbott: I have heard so many stories like that. The arbitrary cut-off of six months does not necessarily meet with the reality of sick people.

Graham Stuart (Beverley and Holderness) (Con): The case of Maria, and others, should give us all pause. Does the right hon. Lady agree, with two thirds of the Cabinet apparently supporting this measure in principle, that we should reject the Bill today, but that we should as a House commit not to go another 10 years ignoring this topic, but to come forward in a considered way, ensure it is looked at properly, and do everything possible to have a system that is more robust, more caring and ensures good outcomes for people like Maria?

Mr Speaker: Order. Let me also say that we must try to keep to the time limits.

Ms Abbott: I agree with the right hon. Gentleman. As I said right at the beginning, I am not against assisting dying in any circumstances. If the Bill passes, we will have the NHS as a 100% funded suicide service, but palliative care will be funded only at 30% at best. The former Member for Dunfermline East, Gordon Brown, has said recently:

> "we need to show we can do better at assisted living before deciding whether to legislate on ways to die."

I represent very many vulnerable people in marginalised communities. I cannot vote for a Bill when I have doubts about whether they will be protected. We can come back, have a commission and craft a better Bill, but I will not be voting for the Bill today.

10.50 am

Mr Andrew Mitchell (Sutton Coldfield) (Con): I want to make three brief points. First, I have completely changed by mind on this subject since I entered the House during the last century, because I have sat in my advice surgery with tears pouring down my face listening to constituents who have set out so clearly, speaking with such emotion, about how their mother, brother, father or child had died in great pain and great indignity.

I strongly support the Bill, and I congratulate the hon. Member for Spen Valley (Kim Leadbeater) on the excellent way in which she has presented it. I believe that we should give our constituents—our fellow citizens—this choice. I want this choice for my constituents; I want it for those whom I love; and I want it, perhaps one day, for myself.

Dr Scott Arthur (Edinburgh South West) (Lab): Will the right hon. Gentleman give way?

Mr Mitchell: I will not, I am afraid. The current law forces people to plan their deaths in secret. Their bodies are found by their loved ones. Often, they die in the most horrific circumstances. They have no chance to say goodbye to their loved ones. It is devastating for their families. The former Health Secretary commissioned the Office for National Statistics to try to find out how many people who committed suicide every year were dying people. The figure was between 300 and 650.

Secondly, in our democracy, the Commons must make this decision. Only we, elected by our constituents, have the legitimacy to do this. It is not the DPP, the Crown Prosecution Service, the police, doctors or even unelected Members of the House of Lords—this House of Commons must make this decision. Let us be clear that all of us on both sides of the debate strongly support an increase in the quality and extent of palliative care. For me, the debate is about extending choice, in very narrow and heavily regulated circumstances under the Bill, as the hon. Lady so clearly set out—the choice not to be forced to end your life in pain and indignity. No element in the Bill talks about intolerable suffering. Many believe that the Bill is too narrowly drawn. I stand by the hon. Lady's drafting. We should remember that in Oregon there has been no serious attempt to change or amend the law.

I had the privilege of speaking to an NHS consultant last year, the day before she headed to Dignitas. She said, "I love my country, but I object very strongly to my country forcing me to make this choice, and to having to travel unaccompanied to a foreign country to die." The status quo is cruel and dangerous. People caught up in these circumstances have no transparency; there is no regulation, safeguards or oversight. The Bill contains a whole series of safeguards that are not present at the moment.

Thirdly, we are deciding today on a principle. If the Bill is voted down on Second Reading, that will be the end of the matter for many years, and we will do that in the knowledge that Scotland, the Isle of Man, Jersey and many other countries are likely to bring in legislation like this. There are 300 million people in 30 jurisdictions who have secured this ability to choose. There will be numerous safeguards. There will not be a slippery slope unless this Parliament agrees to there being one. If we agree to a Second Reading today it is, in my judgment, inconceivable that the Government Front Bench will not ensure we have the proper time to scrutinise the Bill.

This Bill goes with the grain of our constituents' views—about 75%, according to the most recent polling. There is an opportunity and a chance, as the hon. Member for Spen Valley has set out, to consider in detail these matters ahead of Third Reading. As drafted, the Bill seems to me a very modest and controlled proposal. Let us not forget this: Oregon shows us that fewer people take these steps once they know they have this choice as a back-up.

I end with something I have never forgotten. Some years ago, I was listening in a debate to a young man who had recently lost his father. He had visited his father and seen him in great pain and indignity. He had seen him three days before he died. In the end his father put a bag over his head and used his dressing-gown cord to hang himself. That young man said to all of us: "If you are ever in this position, let's hope that God will help you, because they certainly won't." Today, this House has the opportunity to ensure that they will.

10.56 am

Andy Slaughter (Hammersmith and Chiswick) (Lab): It is a pleasure to follow the excellent speech of the right hon. Member for Sutton Coldfield (Mr Mitchell). In preparation for today I have had a number of discussions with my hon. Friend the Member for Spen Valley (Kim Leadbeater), and I want to put on record that the measured way she has dealt with the proceedings has been excellent. I do not know whether she has ever had moments of doubting whether this was the right thing to pick as a private Member's Bill, but she has been an absolute credit to this House in the way she has dealt with these matters so far.

In 2015, in the last Chamber debate on this subject, I wound up for the Opposition Front Bench, but my interest in it goes back much further. Like all Members of this House, I have had hundreds of emails from constituents on both sides of the argument. Many ask me to oppose the Bill; those emails come from people of faith, and I wholly and entirely respect what they say, but they are the first people also to say that this is an individual decision for every individual Member of the House to make.

As I have been at the bottom of the list of speakers to be called for so many years, I have great sympathy for those who find themselves there today, so I will try to keep my remarks to one narrow point: the legal context of the Bill. There is a false dichotomy that the law as it stands is fit for purpose, that we go into the unknown with the Bill before us and that we should somehow keep the safety of the status quo. I think that could not be more wrong. There are no safeguards in the current law. The only sanction against coercion is ex post facto; we are leaving it to individual directors of public prosecutions to make decisions in individual cases after the event.

DPPs take that job extremely seriously, as anyone knows who has heard Sir Max Hill, the last DPP to speak on the subject. They have, at the instigation of the courts, set out guidelines—I think we know that it was an excellent Director of Public Prosecutions who set out the guidelines on this case. They have done everything they can, but it is not their responsibility; it is our responsibility, and the courts, up to and including the Supreme Court, have made that clear.

We assign in this Bill a role to the High Court as part of the process, but we are the final decision takers. That has been made clear not only by domestic, but by international courts; the European Court of Human Rights has said in every case in which such matters have come before it that the margin of appreciation should be put into effect and therefore it should not interfere with the law as we decide it. We cannot dodge our responsibilities and I know that we do not want to do that. We have a duty to put in place the best law we can, and that is not the law as it stands.

There are three choices for people who want to end their own lives. They can go to Dignitas alone, if they can afford to do that. They can attempt, and perhaps succeed in, suicide. They risk failing. If they succeed, they will have a lonely death. They may, as others have pointed out, simply have to resort to refusing treatment or food. The third option is that they can embroil their relatives or friends, at the risk of their being investigated or prosecuted. They also risk ending their lives too soon.

On safeguards, I do not follow the view of opponents of the Bill. At some times they seem to say that they are too complex, too expensive and that there are not enough resources. If we want to resource the Bill, we can. I do not think that those are the strongest arguments.

Jonathan Davies (Mid Derbyshire) (Lab): Will my hon. Friend give way?

Andy Slaughter: I really do not want to, because of the time. I am sorry. *[Interruption.]* Should I? I will give way once.

Jonathan Davies: My hon. Friend talks a little about safeguards. I invite him and the House to reflect on the covid pandemic, when a lot of safeguards around a lot of things were relaxed. I worry that if we were to see another pandemic on the scale that we saw in 2020, people might feel that they were doing something patriotic by getting out of the way and freeing up a bed for a younger person. I invite him to reflect on that.

Andy Slaughter: In practice, a terminally ill person will need to formally consider their decision at least eight times under the provisions in the Bill. This is a starting point—a number of Members have made that point. I believe the Bill has already had more scrutiny than most public Bills we consider, but we have up to nine months before us to consider it further.

All the practical and legal considerations point towards the Bill. It may well be amended to change the safeguards or the way it operates, but we have the opportunity to do that. In the end, for me, that is not the decision. The decision is about two things: it is about human dignity and it is about agency. I would like to think that even at the end of life—no, especially at the end of life—when someone has their faculties but may be at their weakest ebb, they can still exercise that agency and still make decisions for themselves. They can have the longest life they can and they can end that life in the way that is most beneficial to them, their loved ones and their family. That is simply not happening, and by voting against the Bill today Members ignore those facts.

11.3 am

Kit Malthouse (North West Hampshire) (Con): When I was a child, my parents shielded me from death. Centuries of art, literature and religion taught me that death was something noble or even slightly romantic. When I became an adult, I learnt pretty quickly that that was not the case. For far too many, it is anything but and certainly not noble. The deathbed for far too many is a place of misery, torture and degradation, a reign of blood and vomit and tears. I see no compassion and beauty in that, only profound human suffering. In 10 years of campaigning on this issue, I have spent many, many hours with dying and bereaved people, which has, time and again, reinforced my view.

I am a co-sponsor of the Bill and I am the co-chair of the all-party parliamentary group for choice at the end of life. I could give a speech to promote the Bill, but my hon. Friend—and I do call her a friend—the Member for Spen Valley (Kim Leadbeater) has done that remarkably well. In my speech I want to address some of the common issues that have been raised, and that will no doubt be raised during the debate, with which I struggle.

[Kit Malthouse]

First, we will no doubt hear an awful lot about the overseas experience. I am married to a Canadian, and I can tell the House that they love their children just as much as we do. The idea that the Canadians, Australians, New Zealanders, Spanish and Austrians care little for their relatives, or indeed for the wider society in which they live, is frankly offensive. We should not pretend that somehow we are special or different. They have thought as profoundly on these issues as we have over the past 10 years. We can learn from them, and design a system for our own sensibilities and culture, as they have done. They all have different laws on abortion, some of which we would not pass in this House, but that does not mean we should not have abortion laws here. We are a 1,000-year-old democracy, and we should be able to design legislation that deals with this issue for ourselves.

The second issue that has been raised with which I have struggled regards the impact on the NHS and on judges. People are already dying; they are already in the national health service and entitled to care. Even if we think there will be an impact, are people seriously telling me that my death, my agony, is too much for the NHS to have time for, or too much hassle? It is even claimed that such matters would overload the judges—that I should drown in my own faecal vomit because it is too much hassle for the judges to deal with. We send things from this House to the NHS and to judges all the time. Is anyone suggesting that we should not create the new offence of spiking, which has come through this week, because judges are overworked? Of course not. They will cope as they have done with all sorts of things that we have sent from this House over the years, and we should not countenance the idea that some logistical problem will get in the way of our giving a good death to our fellow citizens.

I also want to address directly those Members who are considering voting against the Bill, to ensure that they are clear in their minds that a vote against the Bill is not a passive act. There are two states of being on offer today. I have to break some news to Members: whatever happens to the Bill today, people with a terminal illness will still take their lives. If the Bill falls today, we will be consigning those people to taking their lives in brutal, violent ways, as they are at the moment, and will see increasing numbers of our fellow citizens making the trip to Switzerland if they can afford it. We know that between 600 and 700 people a year are killing themselves in violent ways—shooting themselves, throwing themselves in front of trains, taking overdoses in lonely, horrible circumstances. As I said, many are going to Switzerland, but more than that are lying in hospital—I guarantee that there will be somebody over the river in St Thomas' hospital now who is refusing treatment and starving themselves to death because they cannot face what is in front of them.

Sam Rushworth (Bishop Auckland) (Lab): Does the right hon. Gentleman agree that we had a choice today? We have come here to debate assisted dying, but we could have come here to build cross-party consensus on how finally, once and for all, to fix palliative care in this country. We could have come to look at a funding consensus, as that does need to be cross-party. I agree with his point that voting no is also a choice, but what follows from that should be a cross-party consensus on how we fix palliative care.

Kit Malthouse: I agree with the hon. Gentleman, and what a surprise it is that the conversation about palliative care has started. We were not having that conversation before this Bill came forward. The evidence from the Health and Care Committee, published only in February this year, shows that palliative care and assisted dying go hand in hand.

Mr Perkins *rose—*

Kit Malthouse: I will not give way.

Improvements also go hand in hand; medics from across the world told us that the two things are complementary. In Australia I discussed this issue with a palliative care doctor who was against the introduction of assisted dying when they were contemplating it. She now finds it an invaluable tool, and she embraces it as something that her patients want and need. My concern is that if the Bill is turned down, as it was in 2015, the conversation about palliative care will wither, as it has done for the past 10 years.

I want to share a story that has particularly affected me. Mark Crampton was a former police chief inspector who was suffering from chronic obstructive pulmonary disease. His COPD became too much for him, so he informed his family that he was going to take his own life. He took his oxygen tank and mask and late one night went out and sat on a railway embankment. He wanted a death that was instant and quick, and that he could rely on. He waited until 2 in the morning—heartbreakingly, he had worked out when the last train was going, so he would minimise disruption to the public—and then took his life in lonely circumstances in the middle of the night. By not passing the Bill, we would deny to Mark supervision, conversation, access to doctors, periods of reflection, advice. Even if he had been through all that and decided it was still too much, the Bill would give him a much better end than he actually achieved. Members should be clear, as I say, that whatever happens to the Bill, terminal people will still take their lives.

I have to say to the hon. Member for Brent West (Barry Gardiner), who says that hundreds of people dying in agony every year is a price worth paying for the good of society, that I find that an appalling prospect. A society that looks away from these people —like those in the Public Gallery who are living in terrible fear of what will face them, or who have watched their families die in fear—and says that that is okay for the good of the whole is a terrible, terrible prospect. We have a duty to assist them, as other countries around the world have done, and to find a way to make them comfortable in the end.

Mr James Cleverly (Braintree) (Con): Will my right hon. Friend give way?

Kit Malthouse: I will not.

Finally, I want to talk briefly about rights. We hear a lot about rights in this debate—quite rightly. We hear about the rights and fears of the disabled community, who are specifically excluded from the Bill; we hear a lot about the rights and fears of the elderly, who are also specifically excluded from the Bill; we are even hearing about the rights of doctors, who are allowed to conscientiously object to participating in this process, if they wish. When are we going to have the conversation about the rights of the dying? Where do we put them in the ranking of rights, as they face their end? When do we grant them the autonomy and choice for which so many of them have campaigned over the years? Surely, as they come towards the end of their life, their rights have to be at the forefront of our mind. The last, best gift we can give them is control over the disease that is destroying them.

If we do not pass the Bill today, we are cornering all those people; we are trapping them, with the law, in their disease, and consigning them to an end of torture and degradation that they do not wish to go through. As I said before, we are a 1,000-year old democracy. It is not beyond us to design legislation that will give those people what they want, while protecting those whom we feel need to be protected. Like my right hon. Friend the Member for Sutton Coldfield (Mr Mitchell), I want this choice for my constituents, but profoundly I want it for myself and for the people in the Public Gallery who have worked so hard over the past decade to get us to change our minds.

I ask Members please to be clear that whatever happens today, terminal people will still take their own lives—all we are deciding today is how.

Several hon. Members *rose—*

Madam Deputy Speaker (Caroline Nokes): With the reminder that there is no formal time limit, and if we wish to get in as many Members as possible, could Members please constrain themselves to about eight minutes?

11.13 am

Rachael Maskell (York Central) (Lab/Co-op): This is hard, Madam Deputy Speaker. With compassion, we search for ways to best alleviate pain and suffering and ensure that those we love die in peace. Initiated by the Bill, focus has rapidly turned to caring for the dying and optimising every moment of the life that we want to hold on to; it breaks us knowing that at some point we have to let go. That was the mission of Dame Cicely Saunders, founder of the hospice movement.

Thankfully, most die in peace, but tragically not all. Funding for palliative care has regressed against rising demand in an ageing society with growing comorbidities. Hospices are paring back services. Research by the Anscombe Bioethics Centre in Oxford highlights how jurisdictions with assisted dying fall down the rankings on palliative care, while promised funding never materialises. When more than 100,000 people, predominantly in poverty, from minoritised communities or based on postcode, fail to access any palliative care despite needing it, or when those who access care do so from frequently overstretched services, unable to make timely or optimised interventions, or when, for most, care starts far too late, tragic testimonies follow, as we have heard in recent days.

We all know that the NHS is under significant duress, and just cannot do what it should. Social care is fragmented and costly, and palliative care is significantly underfunded and inequitable. This is a mess. Following Lord Darzi's devastating report, we must give my right hon. Friend the Health Secretary the opportunity to reset health and care. I believe that that is what we on these Benches were elected to do.

With just 17 days since publication, this Bill has consumed us and that will only intensify if it proceeds. Instead, our focus should be on getting palliation right and then seeing what is really needed. We cannot do both as there is simply not the capacity. More than 70% of the public say that they want a commission on palliative and end-of-life care before we consider assisted dying. Other polls agree. Plans for a commission are well advanced.

Sir Roger Gale (Herne Bay and Sandwich) (Con): I agree with the hon. Lady entirely: the way forward should be through better palliative care and not through assisted suicide. The Bill does not address the needs of children. Would she recognise that we also need better palliative care for children as well as adults?

Rachael Maskell: I completely agree with the right hon. Gentleman, who makes a pertinent point. After all, we would never write a prescription before making a diagnosis, yet this Bill does that. It is simply prescribing the wrong medicine. Extraordinarily, there is no critical analysis, not even an impact assessment, when such significant matters of life and death are at stake and when our broken health and justice system would be stretched even further.

My constituent was just 46 when she received a terminal diagnosis. She did not have long; the cancer was advancing and the prognosis would have qualified her for an assisted death. Had it been law, she would have consented. Now 54 and in remission, she pleads that the Bill should not pass. Palliative care consultants say that it is nearly impossible to prognosticate at six months; just 46% get it right. Experts say that the arbitrary six-month threshold is insecure. We must recognise its prematurity. Clause 2(2) says that someone for whom treatment only relieves symptoms but does not cure them would qualify for an assisted death if they were within the criteria. We understand someone declining chemotherapy, but the provision extends to any condition where a cocktail of drugs is sustaining life. The person involved may be only 18. That would not need a change in the law; it is written in the Bill.

My greatest concern is coercion. We live in a coercive society; the UK spends £40 billion on advertising and ever more powerful algorithms drive us to content online. We recognise coercion in relationships or elder abuse, but the Bill fails to safeguard against it when someone is dying and there is malign intent. People often recognise coercion only after years have passed, yet within a month someone could be dead. Malign coercion cases may be few, but as a clinician working at the fringes of life, I heard my patients frequently say, "I don't want to be a burden," or "I'd rather the money went to the grandchildren than on my care," or "Somebody is more deserving than me."

Intrinsic coercion is very real, not least where the law has changed—rapidly becoming an expectation, verbalised as a duty to die. In fact, not wanting to be a burden is cited as a major reason to opt for an assisted death, alongside loss of dignity, loneliness, and needing personal

[Rachael Maskell]

care, yet every day, disabled people live in this reality. We fight in this House to take away stigma and give dignity, equality and worth. That is why disabled people fear the Bill: it devalues them in a society where they fight to live.

We should understand why Disability Rights UK opposes and why Liberty opposes: to push back against the Bill is the cause of the progressive and the libertarian, not just the domain of the conservative. Under this Bill, a doctor may raise an assisted death with their patient—clause 4(2). Given the trust we place in doctors, not least when people are vulnerable, this is so significantly coercive. Let us suppose there is unconscious bias, which is well known in healthcare. Before people question that assertion, let me cite the industrial application of the Liverpool care pathway, and then, five and a half years after its ban, the covid "Do not actively resuscitate" letters. The evidence shows that disabled and ethnic minority people experience bias in healthcare. Those who stand for equality will recognise the safeguarding failures in the Bill. While not wanting to encourage suicidal ideation, rates are 6% higher in jurisdictions where there is assisted suicide.

On the process, two doctors—possibly unknown to the patient—ask a set of questions. It can take days to establish capacity in the courts, but it only needs a consultation. That is the same for assessing coercion and prognosis. Doctors are proponents of assisted dying. Risk increases in closed environments. At least the Isle of Man is considering a parole board-style approach; this Bill does not. The documentation of the decision fails in its rigour, not even seeking evidence for the decision. It is passed to a judge.

Sir James Munby, former family division president, describes,

> "a scheme which does not provide for an open and transparent process but, on the contrary, permits a secret process which can give us no confidence that it will enable the court to identify and prevent possible abuses."

In decrying how the Bill changes the role of the judge to one of certifying compliance, he states,

> "the Leadbeater Bill falls lamentably short of providing adequate safeguards,"

describing the suspension of any appeal as an "extraordinary" omission, not least if the patient's concerned relative or physician cannot take their case. That is backed by Thomas Teague KC, former chief coroner, who said the safeguards "will not hold" and that they

> "amount to nothing more than arbitrary restrictions, with no rational foundation."

Lord Sumption, former Supreme Court judge, highlights that once the law facilitates assisted suicide, it could be deemed discriminatory to deny others—disabled people—the same right. Barristers say they will take cases. They expect the law to change.

Lewis Atkinson: Will my hon. Friend give way?

Rachael Maskell: I will press on.

Much would rely on regulations using the negative procedure, and some the affirmative. Even if not prepared within two years, clause 42(3) says the Act would be fully implemented. The Bill changes the role of the chief medical officer without any analysis, as is the case for doctors. During the 14-month Health and Social Care Committee inquiry, we heard how the clinician-patient relationship changed with assisted suicide. Record keeping and data collation is inadequate, as we found in Oregon.

Clause 18(9) highlights that the procedure may fail. The Bill is silent on how to manage such cases, but it should be explicit. We must acknowledge that it is not always peaceful. We learned in Oregon that some have seizures or vomit as the body rejects the toxic medication.

The Bill falls woefully short on safeguarding patients, too. It is too flawed to amend. It is a wrong and rushed answer to a complex problem. Today, we must be beyond reasonable doubt of error if voting for the Bill. Remember, the vote is not on the principle of assisted dying or on choice, but the principles detailed within the clauses of the Bill. Polling overwhelmingly says that if Members are in any doubt, the public expect them to vote against the Bill today. We can focus on optimising palliative and end of life medicine to build consensus and to discern what further steps need taking. For death, as with life, is too precious to get this wrong.

Madam Deputy Speaker (Caroline Nokes): I call the Chair of the Health and Social Care Committee.

11.23 am

Layla Moran (Oxford West and Abingdon) (LD): I congratulate the hon. Member for Spen Valley (Kim Leadbeater) on bringing the Bill. I commend her for the tone she has set in shepherding the debate and, indeed, I commend Members across the House with sincerely held views for the way we have done this so far—I hope it will continue.

Most things we do in this place have some bearing on life and death, but it is rare we discuss those concepts in their most visceral and direct forms. As a nation, we do not talk about death nearly enough, especially while we are well, but it happens to us all, so I welcome the chance to enable better conversations not just in this place together, but in people's own minds for themselves. No matter how anyone votes today, I hope that we can all agree that this debate is a profound and proud moment for our democracy.

To that end, I want to be up front: I will be voting for the Bill today, because I want this conversation to continue. To those arguing the moral grounds and making the point that we are crossing the Rubicon, I sincerely respect their views. These are moral judgments. There will be Members who are making the moral case, and I want to hear them. But I urge those MPs who might be minded to vote for the Bill on principle, but are worried about the details—how we might change a word, the role of clinicians or MPs, or whatever it may be—to reconsider the question they are asking themselves today.

This is Second Reading. The media are asking all of us, "Are you for or against the Bill?", but I urge hon. Members to think about the question differently. The question I will be answering today is, "Do I want to keep talking about the issues in the Bill?" I am asking myself if I want to keep grappling with the detail until I get to Third Reading, when I might reserve the right to vote no. They can decide the answer to that question for themselves.

Mr Cleverly: I appreciate the hon. Lady giving way, but she is misrepresenting what we are doing at this point. We are speaking about the specifics of this Bill: this is not a general debate or a theoretical discussion, but about the specifics of the Bill. My hon. Friend the Member for East Wiltshire (Danny Kruger) has highlighted numerous deficiencies, and I will provide one example. If the proposed legislation is such a good thing to alleviate pain and suffering—a right that we should be proud to pass—why are we denying it to children? If it is a positive, why are we denying it to children? We are discussing the specifics.

Layla Moran: The right hon. Gentleman might want to raise that issue in Committee, at a later stage. However, it is important for hon. Members to appreciate that they can vote yes today, and vote no later.

I want to come on to palliative care, which is really important. The message from the sector, patients and their families is crystal clear: palliative care is not good enough and we must do better.

Mr Lee Dillon (Newbury) (LD): Does my hon. Friend agree that we are not talking about a choice between palliative care and assisted dying? The two can go hand in hand, but with the knowledge that if palliative care does not provide the individual with the comfort they require, the Bill would give them the option to decide how they want to end their life, rather than drifting away without being able to have a final cuddle or say a final goodbye.

Layla Moran: There needs to be a debate around palliative care. My concern is that we have not had any firm commitments from Government, other than woolly words, about how they are actually going to tackle the issue, and that a royal commission will push it into the long grass.

I say to the Secretary of State for Health and Social Care, who is in his place, that the gauntlet has been thrown down. If he wants someone like me to not vote for the Bill moving forward, he needs to do two things: he needs to put firm commitments on palliative care on the table and resolve them within the next one or two years, and then, afterwards, commit to bringing back a Bill like this one in Government time. Without those firm commitments, I will continue to make the case for wanting to see progress.

Imran Hussain (Bradford East) (Ind): The hon. Lady and I come to this subject from different places, as I will be voting against the Bill. I agree with her and all the hon. Members who have spoken about the need to massively improve palliative care, but she says we can address some of those concerns at a later stage. How does one address coercion and guilt through legislation?

Layla Moran: These are conversations that I want to keep happening, but I say to those who are making the argument about the process and asking how we can make that better, what does a Bill that addresses assisted dying that they might vote for look like? If the answer is that there is none, let us be honest about that.

I want to end by giving a tiny amount of my time to someone who is in the Gallery today. Tracey, I cannot see you right now, but thank you for coming. I said to Tracey, my constituent, when we met that I would allow some of her words to be spoken today. Tracey was 58 when she was diagnosed with incurable stage 4 breast cancer, which spread to become a brain tumour in 2023. It was successfully removed, but Tracey lives every day knowing that her cancer is likely to return. These are the words Tracey wants us to hear:

> "Despite this prognosis I can honestly say that I am a happy person now. I feel lucky to have made it to 60. There is just one black cloud on the horizon for me, and it is the way that I will die. I am terrified that I will suffer a long, painful death. If I knew I had the choice to have a good death, these worries would disappear. Please change the law so I can live what life I have left, safe in the knowledge that I have a choice about how and when I die. If you do this, I will be able to live even more happily today knowing that I do not need to worry about the prospect of a cruel and painful death."

I will end by saying that there are sincerely held views being heard today. Let this be this Parliament that ensures, regardless of how we vote today, that we give people a good death.

11.31 am

Tonia Antoniazzi (Gower) (Lab): I have led two Westminster Hall debates for the Petitions Committee on the subject of assisted dying. I have grappled with this subject, and I still do. When my hon. Friend the Member for Spen Valley (Kim Leadbeater) was speaking earlier, I had a packet of tissues, and I made swift work of them. It really is so difficult for so many us, with our personal experience and our own thoughts.

It is genuinely our privilege to be able to say that this is what we want or what we do not want. We may not be facing this right now in our lives, but when you are, you think about it deeply. I will be voting for the Bill today. I think about this all the time—I need to maybe get a bit of a life—because it really is something that bothers me. It is an honour for all of us in the Chamber to be able to debate this today, whatever our views. I have to say, this is just not easy. I want everybody out there to know that it is not easy. It is really difficult, and it is difficult for those on both sides of the debate.

I will get to the Bill now, because as has been pointed out, we are here to talk about the Bill, not to get overly emotional. I want to talk about how it impacts Wales. I hope we will be able amend the Bill to take consideration of these things, and I hope that we can look at this in detail in the Lords. I believe that the Bill should pass today, because we need to discuss it and know how it is going to work. As it is currently drafted, we will need to look to the Welsh Government to see if there needs to be a legislative consent motion, because it does not seem to engage with the Sewel convention in a substantive way.

Issues that have been raised with me include that the Bill places multiple duties on the Secretary of State in England around codes of practice and ensuring assistance within the NHS. The Welsh Government need to be happy with the Secretary of State in England deciding how services are to be provided within the Welsh NHS. There will need to be an amendment, which I suspect will then engage with the Sewel convention.

The need for subordinate legislation to enact the Bill is really complicated, and we need to see how it will be passed in this place. There are issues around the codes of practice, because some of them are devolved. I want

[Tonia Antoniazzi]

to highlight that, because regardless of the emotional stories that we will hear today, we need to mindful that the Bill has an impact on legislation in Wales. It is very important that if the Bill does go through today, those discussions are had, because everybody's life matters, and we have to get this legislation right.

I do not want to take up any more time, but I thank all my hon. Friends and, in particular, my hon. Friend the Member for Spen Valley, who has been an absolute gem.

11.34 am

Dr Ben Spencer (Runnymede and Weybridge) (Con): Prior to my election to Parliament, as a consultant psychiatrist with a PhD in decision-making capacity, I would have met both criteria to be a medical expert assessor under clause 9(3)(b), so I have a particular perspective as someone who, in different circumstances, might have been called upon to make these assessments.

I strongly believe that we should respect and support the right to bodily autonomy for people with full decision-making capacity, subject to the caveat that it does not cause serious harm to others. I argued for this when I was on the working group of the independent review of the Mental Health Act 1983 and on the pre-legislative scrutiny Committee on the Mental Health Bill, which, among other things, aims to prevent people from coming to harm when suffering from severe mental illness. These reforms were debated in the House of Lords this week, and they demonstrate how Parliament should legislate in complex areas that balance individual autonomy and risk.

In contrast, as a private Member's Bill, there is limited ability for scrutinising this Bill's provisions. It has had no independent review, no pre-legislative scrutiny and no impact assessments. Many MPs support the principle of assisted dying yet have concerns about implementation, resource implications and safeguarding. That is why I, along with colleagues on both sides of the House, tabled a reasoned amendment calling for an independent review and consultation before a vote in Parliament, to provide a third way through. I thank the Members who supported the amendment, particularly the hon. Members for Shipley (Anna Dixon) and for Twickenham (Munira Wilson), for their work and their extensive and careful consideration.

Although the general debate on assisted dying may focus largely on the principles, legislation must address the limits to and the safeguards on consent. Should people be able to agree to a medically assisted death? If so, what restrictions, if any, should there be on people who can make this decision—age, capacity, terminal illness, intolerable suffering? And then, what safeguards are there to uphold these limits and to prevent abuse—assessments by two doctors, judicial scrutiny?

Given that the main argument I see in favour of assisted dying is the exercise of personal autonomy, I believe the most substantive issues we need to wrestle with are the limits that we set. Why is this Bill limited to the terminally ill and not those who are suffering without that being terminal? What even comes within the scope of terminal illness? With the refusal of treatment and medication, conditions such as type 1 diabetes and HIV can be designated as terminal, despite being fully treatable.

There are many questions, but in this Bill the most prominent problem is that, in a legal context, if the availability of assisted dying is limited only to those who are terminally ill, it is discriminatory either to those with or without terminal illness. Either their right to autonomy is greater than others', or the value of their life is worth less.

We must also ask whether autonomy can be exercised where there is no choice. If good palliative care is simply not available, can we really rely on this as a true and free decision? I would argue that we cannot, and that this Bill does not safeguard against coercion through state neglect.

Lola McEvoy (Darlington) (Lab): Will the hon. Gentleman give way?

Dr Spencer: I usually would, but unfortunately that would impact on other Members who wish to speak. I apologise.

What is fundamental to me, given my interest in capacity, is that we have not considered how much human decision making is driven by altruistic intentions. "I did it for my children" is rightly a primary motivation in many settings, but as a society are we comfortable with a decision to seek a medically assisted death so as not to be a burden on one's family or to save them money?

This will not impact on capacity. We cannot pretend that capacity assessments will be a shield for these moral concerns. Where is the line, if there is one, between indirect coercion and the natural human responses in a stressed family unit looking after a sick loved one?

I believe that we could introduce legislation on assisted dying that has fully reviewed and addressed these issues, but parliamentarians must deal with what we have in front of us today. Proponents on both sides of the debate frame this vote on Second Reading as a vote on the principle of assisted dying, but in reality it is a vote on implementation as put forward in this Bill.

As a former mental health doctor, I am proud that I was there for the most vulnerable. Today, I think about those without a voice in this debate or in the TV studios. I think about the elderly woman in the care home with mild cognitive impairment, who retains capacity but is nevertheless vulnerable to coercion and undue influence, or the sick mother whose child may lose their job or their relationship due to the burden of caring responsibilities. The Bill would not protect them. It risks placing implicit pressure on people already vulnerable at a time of life when they should receive our unwavering care and support. We should and must vote it down.

11.40 am

Dame Meg Hillier (Hackney South and Shoreditch) (Lab/Co-op): In my brief remarks today, I want to touch on principle, policy and practice. We have to be very clear that we are having a debate not just on the principle, but on the Bill. The principle at stake is that we would cross a Rubicon whereby someone who is terminally ill, according to the definition in the Bill, is assisted by the state to die. That is a fundamental change in the relationship between the state and the citizen, and the patient and their doctor. If we have a scintilla of doubt about allowing the state that power, we should vote against the Bill today.

Like most of us, I came into politics partly to stand up for the vulnerable, and we have heard heartbreaking stories today about those vulnerable at the point of death. We have also heard—and I concur completely with my right hon. Friend the Member for Hackney North and Stoke Newington (Ms Abbott)—about those who are vulnerable for other reasons and who could be coerced or persuaded down this route.

I have had the privilege of being around the hospice movement for nearly 50 years, as my father established one of the first national health service hospices in this country. I saw what he did as a doctor in a world where death was not talked about, where surgeons would say, "We'll whip this bit out and you'll be fine." He would be one of the first to have to tell the patient that they were actually going to die. The work that he did, on the back of giants such as Dame Cicely Saunders, is something we should be proud of. We were the first country in the world to recognise palliative care as a separate profession, and some of the tragedies we have heard about today arose from a failure in that system. A failure in palliative care and support is not a reason to continue.

I have personal experience of this. Many hon. Members will remember when my daughter was very ill a few years ago. I had not intended to speak about this today, but she was admitted to hospital as a teenager with acute pancreatitis. The Bill would not have covered her, but I did not know for five days—in fact, many months—whether she would live or die. For those first five days she did not sleep and she did not eat, and she was crying out in pain. I saw what good medicine can do. It palliated that pain and got her to a place where, although she was unable to eat for two and a half months, she was saved and her pain was managed. Our best friends were the pain nurses and the anaesthetists. I have other examples of another family member, but I do not have time to go into them today.

I hope my daughter forgives me for raising her personal situation in the House today—

Lola McEvoy: Will my hon. Friend give way? I pay tribute to her for the strength that she is showing. Indeed, I pay tribute to all Members on both sides of the House who are dealing with this very difficult issue. Does she agree that we already have assisted dying in this country? Legislation already allows for choice, proving that people would be able to die at home with carefully administered, practitioner-led pain management. Does she agree that the inconsistency of this application of good pain management at the end of life, causing compassionate legislators to feel that the only option is to vote for the Bill, is a failure of our existing national health system, and does she—

Madam Deputy Speaker (Caroline Nokes): Order. Interventions will have to be short in this debate because many Members wish to speak, so perhaps that is enough.

Dame Meg Hillier: I thank my hon. Friend for that intervention. She is absolutely right. When we see the system working, it is great, but some of what we have heard today has referred to a failure of the system. That cannot be a reason for us to accept the Bill today. For more than 30 years I have been scrutinising the policies and actions of public bodies and seeing the mistakes that they make, both in the care sector when I was in local government and more recently as Chair of the Public Accounts Committee.

Mr Adnan Hussain (Blackburn) (Ind): The time for us to make this decision is wrong, frankly. At a time when 44,000 terminally ill pensioners are set to lose their winter fuel allowance—indeed, many of them have lost it—we are discussing whether we will pass a Bill, a state-sanctioned Bill, dealing with a taboo that many of us are reluctant to talk about.

Dame Meg Hillier: Where I do agree with the hon. Gentleman is that the time is not right. We have not had the proper discussions about palliative care. Some of us have been trying to talk about it for many years, and we need to ensure that this debate does not stop today, but the Bill must stop today. It is not developed to deliver the palliative care resource that we need. I do want to touch on the policy, but let me first return to the point that I was making before the hon. Gentleman's intervention.

We have seen many failures in the system, including contaminated blood, and whistleblowing in the NHS repeatedly shows such failures. There is great trust among those who support the Bill that these safeguards will deliver. I will not go into the details, because others have already done so, and I am sure that many more will, but we made coercive control illegal in 2015, and although the Bill refers to safeguards, I fear that that will not pick up coercive control. When we ruled it to be illegal, we thought that was a moment of progress in the House.

Given the time, I will now move on to some of the practical challenges. My constituents are struggling to see doctors face to face, and seeing the same doctor twice seems like a miracle in today's Britain. My right hon. Friend the Health Secretary is trying to sort it out, but it will take a long time. We need to sort out our battling health service, we need to support palliative care, and we need to discuss what a good death is. Cicely Saunders campaigned and triumphed to ensure that we had one of the best hospice movements in the world.

If Members have any doubt in their minds about the impact of the Bill on people who do not have the same capacity as those who are talking about this in the television and radio studios, they should think of those in my constituency who have poor English, or the woman who came to see me a month ago with terrible pain in her gall bladder. Removing it would have been a simple daytime operation, but she did not understand what the doctor had told her, and she was not going to have her gall bladder taken out because she did not know what it meant to be without a gall bladder. Let me say this to those Members: if someone who was English, a bright woman in her 60s, was unable to challenge what was said to her and to have that conversation with a doctor, just think what passing the Bill today would mean for many more vulnerable people.

I thank the House for its indulgence.

11.48 pm

Sir Edward Leigh (Gainsborough) (Con): I pay tribute to the hon. Member for Hackney South and Shoreditch (Dame Meg Hillier), and I want to follow her in talking

[Sir Edward Leigh]

about palliative care. Let me start by reading an email that was sent to me only yesterday by a personal friend and constituent:

> "I apologise for adding to the thousands of emails you will be receiving. I just wanted to tell you why I oppose the right to die Bill. I know you are aware of the experience I had when my husband was dying. In hospital we had a dreadful experience because they had no end-of-life care and he suffered. Once in the Hospice it was a different story and he received the loving care he rightly deserved.
>
> My argument is that, instead of assisted dying, we should be spending much more money on end-of-life care and funding the wonderful Hospice movement. Thank you for reading this."

I will read another letter, from a doctor, which I think encapsulates some of the problems that we encounter in this issue:

> "Only recently, I was giving my condolences to a grieving woman who had lost her husband in the early hours. He had been given a few small doses of pain relief and mild sedatives over the last few nights for symptom control and had passed away peacefully at her side. She asked me in all seriousness, 'Doctor, did the nurses give him something to make him die quicker last night?' This was an awful lingering doubt that she had. I was able to firmly reassure her that, no, the medication would not have sped up his passing.
>
> For her, and the vast majority of other patients, doctors are there to prolong life and palliate symptoms. Were this to change, then we would not be doctors in the eyes of many, but bringers of death, agents of a state which counts its weakest members as expendable and worthy of nothing but an early grave.
>
> I do not want to be a member of a profession which has that reputation or role".

Those are two witnesses who have written to me. I have taken an increasing interest in this whole issue of palliative care, and the law frankly—

Mr Perkins: Will the right hon. Gentleman give way?

Sir Edward Leigh: Will the hon. Gentleman forgive me if I do not? I know that many people want to speak. I just want to develop this argument, then I will finish.

The law is so unclear. I have talked to a number of palliative care specialists, and they say that we can give as much morphine as we want to a patient and we will not kill them, but there is real doubt in the minds of the public. A lot of the impetus around this debate, and the reason why people in opinion polls are apparently supportive of this measure, is that they are terrified of dying in pain. There is no need for this. When I talk to consultants and practitioners in palliative care, they say that they can manage pain. I was struck by a very touching email that was sent to me by a constituent, who actually supports the Bill on the grounds that when his wife was dying, and he was begging the doctor in a national health hospital to give her more morphine, the doctor said, "If I did that, I would be breaking the law."

I can see the Health Secretary is sitting here, and I really think that if we are going to have a serious debate about this issue, we need to have something equivalent to a royal commission to determine what doctors can and cannot do. It is essential that we really reassure the public. There is tremendous interest in and huge doubt about this issue. Many people are conflicted, and we have heard many moving stories about people's fear of dying in agony, but until we clear this up, I do not think that we can make the progress that this issue deserves. Yes, we have to fund our hospice movement seriously. It is very worrying that we are going to fund the NHS to fund death, but that we are not adequately funding our hospice movement.

Before we take this momentous decision, we have to be realistic about it: if the Bill were to pass at 2.30 pm, that would be it. I do not believe that a private Member's Bill, which has only five hours of debate and on which many Members of Parliament will not be given time to speak, is the right mechanism. In the last Parliament, we discussed a certain subject that we all know about—it was a very different issue. We had hundreds of hours of debate, questions and scores of civil servants crawling over the issue. Surely this issue is even more important. Surely we should have had more than just two or three weeks to consider this Bill. We should be looking at the detail, because the devil is in the detail in respect of possible coercion, the facilities available to the hospice movement and the issues I have talked about, including the lack of clarity in the law as to how we can or cannot relieve pain. Can we not pause a moment? Those are the practical points that I want to make.

This is so important: the futures of so many vulnerable people are at stake. I was struck by the comment made earlier by the hon. Member for Brent West (Barry Gardiner) that we cannot consider this issue just in terms of individual hard cases. We must consider it in terms of society as a whole. What sort of society are we? Are we a society that loves our NHS, that loves life, that loves caring and that loves the hospice movement? Or are we a society that believes that there is despair? I will vote for hope at 2.30 and I will vote against the Bill.

11.55 am

Peter Prinsley (Bury St Edmunds and Stowmarket) (Lab): I asked the ear, nose and throat nurse I have worked with for 20 years about assisted dying, and she said it is an essential change. There is no doubt in her mind. Like me, she has seen the unbearable distress that some head and neck cancers cause, and she knows of the very difficult deaths of some of our patients, despite excellent palliative care. It is this experience that has changed my mind. When I was a young doctor, I thought it unconscionable, but now I am an old doctor and I feel sure it is the right change.

I have seen uncontrollable pain, choking and, I am sorry to say, the frightful sight of a man bleeding to death while conscious, as a cancer had eaten away at the carotid artery. It is called a carotid blowout. I know the terrifying loss of dignity and control in the last days of life. I am speaking here of people who are dying, not people living well who have chronic or terminal diseases. We are talking about people at the end of their lives wishing to choose the time and place to die. This is not some slippery slope. We are shortening death, not life, for our patients. This is not life or death; this is death or death.

Coercion and manipulation have been spoken about and are no doubt feared, but the danger of no change to the law is a greater fear for those who are dying and wish to have choice. The very real fear of loss of dignity and control are at the heart of it. Do not underestimate that. There are strict safeguards in this tightly written Bill, and I fervently hope there will be the opportunity to refine them as it progresses.

Steve Witherden (Montgomeryshire and Glyndŵr) (Lab): Assisted dying is already occurring in unregulated ways, with up to 650 terminally ill people taking their own lives each year, often in traumatic circumstances, causing additional pain for their loved ones. The Bill promotes freedom of choice at the end of life in a controlled and regulated manner. Does my hon. Friend agree that legal assisted dying would provide essential safeguards where there currently are none?

Peter Prinsley: I thank my hon. Friend for that timely intervention. Some may say that we do not have the resources to introduce this change, and many may say that we must invest in palliative care, which of course we must. But I see assisted dying as complementary to, not an alternative to, palliative care.

Melanie Ward: My hon. Friend briefly mentioned coercion, and the well-held fears of many of us in the House about the risk of coercion, particularly for vulnerable people. What does he make of the fact that in Washington state, where the relevant law is restricted to terminally ill people like this Bill, last year 59% of those who went through with an assisted death did so because they feared being "a burden" to "family, friends or care givers"? In Oregon, the proportion last year was 43%.[1]

Peter Prinsley: I respect my hon. Friend's report of the statistics, about which I have no further information.

Colleagues know the gravity of the law that we are discussing and might feel that the moral weight of such a change is simply too great to bear; they may fear that our wisdom is insufficient. But I urge us to be brave today and allow the Bill to progress in this new Parliament.

Finally, a prison chaplain told me only this week of a gentle old man he met in prison, serving life for agreeing against every instinct in a last act of love to suffocate his wife, who was dying in uncontrollable agony. We are a compassionate people and we can do much better than that.

Several hon. Members *rose*—

Madam Deputy Speaker (Ms Nusrat Ghani): Order. Colleagues will realise that we have only a few hours to go. Without absolute speaking limits, if colleagues could keep their contributions to shy of five minutes, I will do my best to get in as many speakers as possible.

12 noon

Tim Farron (Westmorland and Lonsdale) (LD): The motives of those proposing the Bill are grounded in compassion—in the heat of this debate, I want to seriously acknowledge that—particularly the hon. Member for Spen Valley (Kim Leadbeater), who has conducted herself with great dignity throughout. Neither side has a monopoly on compassion—I will always be affected by watching my mum suffer at her death at the age I am now—so let us not think badly of one another's motives; let us instead be courteous and let us be curious.

My opposition to the Bill is grounded in compassion. To legalise assisted dying would be to create the space for coercion that would undoubtedly see people die who would not otherwise have chosen to do so. There are no safeguards in the Bill that would prevent that.

Naz Shah (Bradford West) (Lab): Will the hon. Member give way?

Tim Farron: I had better not.

To be fair, no safeguards would be possible, even if we were not going through this hasty process. First, there is the risk of self-coercion. Many of us will have heard older relatives utter words similar to, "I am a burden to you. You would be better off without me." We all know reasonably instinctively that people will present it as making a sovereign choice, but it will be a choice born out of coercion. Unless there is a clause in the Bill that I have missed to employ mind readers, no amount of doctors, safeguards or bureaucratic mechanisms will prevent those who self-coerce from opting to die simply because they assume that no matter what their loved ones say, everyone would be better off if they were dead.

To add to the stats we just heard from the hon. Member for Cowdenbeath and Kirkcaldy (Melanie Ward), we know that in Canada more than one in three people opting for assisted dying gave as their reason for choosing to die that they felt they were a burden on others. Honestly, I do not see how we need any further discussion to push us into the No Lobby than that clear evidence from where it is legal.

Secondly, there is coercive control. In the last Parliament, we passed groundbreaking and long-overdue legislation on domestic violence. As society's understanding of that often hidden evil has developed, our eyes have been opened to one horrific factor in particular: that of insidious, manipulative coercive control. Thousands of people have been—and are today—victims of those who seek to manipulate their will, take over their lives and coerce them into believing that their perpetrator's will is actually their will. We all know through our constituency casework of people who have been victims. One common theme is that victims often did not realise that they were being controlled until long afterwards. It can take years for the penny to drop. I do not need to spell it out, then—do I?—that for those coerced into choosing assisted dying, that penny will never drop. They will no longer be with us.

Thirdly, people will choose assisted dying because of their pain when they would not do if that pain was properly managed. Here is where the evidence from other countries becomes truly disturbing—in fact, terrifying. In the last decade, the countries in Europe without assisted dying increased palliative care investment by over three times more than those that had legalised it. In the United States, those states without assisted dying saw an increase in the size of their palliative care teams that was also three times greater than that in states that had legalised it. That is clearly no accident and no coincidence. Indeed, the group that have contacted me who are most vociferously against the Bill are palliative care doctors.

Sorcha Eastwood (Lagan Valley) (Alliance): The discussion we are having—and I pay tribute to the hon. Member for Spen Valley (Kim Leadbeater) for the way that she has conducted it—almost implies that palliative care is of the same excellent standard across the UK. I have to inform the House that it is not, which is a matter of deep regret. I cannot stand by the Bill because many vulnerable, marginalised people will be impacted by it. I want to support and affirm life, and I want that to be with dignity.

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[1] [*Official Report*, 6 December 2024; Vol. 758, c. 6WC.] (Correction)

Tim Farron: I thank the hon. Lady for her important and powerful intervention. Those palliative care doctors who have been in touch with me know that to opt for legalised assisted dying is to opt, inevitably, to divert resources away from palliative care—that is the evidence. I spoke to one of those palliative care doctors this week, who works in a hospice. She said:

> "The only patients I care for, are those who are dying".

We all know what is coming. Assisted dying means a shift in focus away from helping people to live in dignity and comfort, towards simply helping people to die. Then, it becomes a self-fulfilling prophecy. Let us not kid ourselves: palliative care is a postcode lottery in this country, especially for the poor and the old. If the motivation of those who choose assisted dying is to end their pain, we can be absolutely certain that those NHS trusts with the weakest palliative care offer will be those with the highest incidence of people choosing to die. In other words, it will not really be their choice at all.

An observation made to me by a senior oncologist just last week was that there are fewer more stressful situations in a person's life than to be given a terminal diagnosis—I remember being with my mum as she was given hers—and to be told you are going to die. The oncologist then explained that among terminally ill people there is a vast amount of severe but undiagnosed depression and psychological illness. Similar but distinct from the danger of self-coercion, there is nothing in the Bill to safeguard against people who suffer like that from choosing to die before their time, yet in so many cases it will be people's mental health that leads them to choose to die, not their physical condition. We simply cannot be all right with that.

Here we are, on the precipice of agreeing to sanction and support the deaths of people in despair. Our society has chosen a dystopian and contagious path if it chooses to facilitate the death of those who have a terminal illness rather than standing with them, weeping with them, valuing them and loving them against the desolation that any of us would feel if we were given a diagnosis of that sort. It is no wonder that the Government's own suicide prevention adviser is strongly opposed to the Bill.

I totally respect that many of my colleagues in our corner of the House—my fellow liberals—will take a different view. I am opposed to the Bill because I am a liberal. Libertarians believe that personal liberty is so important that there can be no fetters on it. But I am liberal, not a libertarian. I believe that freedom is essential and that the rights of the individual underpin a decent society, but my rights must be held in check if they nullify your rights.

Since we know—we really do—that to legalise assisted dying is to permit people to die who will self-coerce, as a consequence of manipulative coercive control, outrageously not because of a real, sovereign choice but because of a heartbreaking Hobson's choice due to inadequate palliative care, I have no right to impose that ultimate and most appalling constraint on the freedom of the most vulnerable in our society. I urge all of us to stand in defence of those most vulnerable people, to defiantly defend their liberty, to make a renewed commitment to world-class palliative care and to human dignity, and to reject the Bill.

Several hon. Members *rose*—

Madam Deputy Speaker (Ms Nusrat Ghani): Order. In consideration of colleagues, please keep speeches under five minutes.

12.8 pm

Dr Marie Tidball (Penistone and Stocksbridge) (Lab): Today's decision has been one of the hardest that I have had to make. In my career in disability law and policy, I chose not to focus on debates about whether disabled people should be born or whether we should die. Instead, I focused on enabling disabled people to live better, more fulfilling lives.

Today, I find myself voting in a way that I thought I never would. I will vote in favour of moving the Bill to the next stage of the legislative process. That has been a difficult journey for me. I have arrived here by looking at the evidence, reflecting on my own lived experience and listening to the many, many constituents who have written to me in support of the Bill, sharing their compelling and tragic stories of death—death which did not come with dignity or respect.

In reflecting on my own life, one moment from my childhood stood out. When I was six years old, I had major surgery on my hips. I was in body plaster from my chest to my ankles, and in so much pain and requiring so much morphine that my skin began to itch. I remember vividly laying in a hospital bed in Sheffield Children's hospital and saying to my parents, "I want to die. Please let me die." I needed to escape from the body I was inhabiting. That moment has come back to me all these years later. That moment made it clear to me that if the Bill was about intolerable suffering, I would not vote for it.

I have subsequently had a good life, a fulfilling life, a life where I have worked towards ensuring disabled people are valued by our society. But that moment also gave me a glimpse of how I would want to live my death: just as I have lived my life, empowered by choices available to me; living that death with dignity and respect, and having the comfort of knowing that I might have control over that very difficult time. For so often, control is taken away from disabled people in all sorts of circumstances.

In order to ensure that there is compassionate choice at the end of life, it is right that the Bill is tightly drawn around the final stage of terminal illness for adults and includes the strongest safeguards. The choice of assisted dying as one option for adults when facing six months' terminal illness must be set alongside the choice of receiving the best possible palliative and end of life care, or it is no choice at all.

Having analysed the Bill closely, therefore, there are changes I would want to see in Committee to strengthen those options and ensure the way that choice is presented by medical practitioners is always in the round. People deserve dignity in death, and for those who do not choose to end their lives in this way, they and their loved ones should feel reassured and safe in the knowledge they will receive the very best of care. I would also want to ensure that the final stages of the Bill properly define "dishonesty", "coercion" and "pressure". I think it is necessary to embed mandatory language in the Bill around the need for a code of practice on palliative care, as well as improving the regulations on training for medical practitioners. I trust my hon. Friend the Member for Spen Valley (Kim Leadbeater) to champion those amendments and to continue to diligently listen to Members, as she has throughout this process.

However people vote today in this House—a decision of conscience—it is incumbent on all of us to commit to improve palliative, end of life and adult social care. It must be the start of the work that we do in this place to ensure the very highest standards in these areas. That will be a very great legacy indeed: giving people the dignity they need in the moment of death. For many of us across the Chamber, considering these issues has been extremely hard and upsetting. We have had to go to the very depths of our selves to understand what choice we will make today. While we may enter different voting Lobbies, we leave this Chamber shoulder to shoulder. I know we will all work in our own ways to make systemic change to improve the lives of our constituents, and people up and down this country.

Several hon. Members *rose—*

Madam Deputy Speaker: A very considerate five minutes—thank you.

12.13 pm

David Davis (Goole and Pocklington) (Con): Thank you, Madam Deputy Speaker. I will try to keep it brief and stick with procedure.

The decision we are taking today must be, for most Members, one of the most painful decisions. It certainly is for me. I am someone who has changed his position. I am a believer in the sanctity of life, but I am also an antagonist to torture and misery at the end of life. Accordingly, I intend to vote for the Bill on Second Reading. I say to those who have made procedural comments that Second Reading is a point of principle, not a point of conclusion. I have changed my position because since the scandal of Dr Shipman and the murders he carried out, the behaviour of the health service has changed. I have witnessed, with constituents in particular, any number of people who have died slowly and in agony beyond the reach of palliative care—the hon. Member for Bury St Edmunds and Stowmarket (Peter Prinsley) made the point brilliantly—so that no matter how well we do it, we cannot fix that problem.

Secondly, I am going to disagree with my right hon. Friend the Member for North West Hampshire (Kit Malthouse): it is not insulting to critique what others who have tried this have done. The countries that have tried this provide a wide range of examples and outcomes. If on Third Reading I think that the outcome we are heading towards is Belgium, I will vote against; and if the outcome is Canada, I will probably vote against. If it is Australia, I will vote in favour. That is what the next stage of this process is about.

I say to both the Bill's sponsors that it has a number of areas that they know I think they have to put right—about a dozen, in truth.

Dr Arthur: Will the right hon. Gentleman give way?

David Davis: I am afraid not, as I have only five minutes.

I will pick one of those areas, as it is technical and awkward. Clause 4(2) appears to give doctors the right to initiate the process. But after the "Do not resuscitate" scandal during the covid crisis, I do not want that at any price—I do not want the state initiating this process. That is critical for me. I am really making the point that the decision on Second Reading is about principle, not outcome.

The hon. Member for Spen Valley (Kim Leadbeater) has said that she will work hard to make the Committee work. I am sure she will, and she may succeed. But I say this to the Government. I understand perfectly well that they are trying to maintain a route of strict neutrality, but there is a distinction between neutrality and responsibility. They need to focus on responsibility. This Bill is more important than most of the Bills in their manifesto; I am not trying to be rude. Is the hon. Member for Clacton (Nigel Farage) here? He got mobbed over breakfast by people talking about this. More people in the Dog and Duck care about this than they do about most other things that we are doing, so it deserves four days on Report in Government time over the course of several weeks.

We do not need a royal commission. The House can do this, but it needs to be given the option. I say to the Government that the path of responsibility is to give us the time to get this right. If we get it right, it will be one of the things that we can be proudest of in the coming years. I reiterate that I want the Bill to succeed. It is more important than most Bills that we handle. It cannot be dealt with in five hours here and a few hours in Committee. I will vote for it today, but I want the Government to help me be able to vote for a good Bill at the end.

Madam Deputy Speaker: I ask Members to please face the Chair, so that we can pick them up on the microphones.

12.17 pm

Anna Dixon (Shipley) (Lab): I am honoured to have been called in this debate. It has been moving to hear contributions from across the House. Feelings have been particularly raw for me, as I witnessed my close friend Sharon dying of cancer over the last few months aged just 55. She had good access to palliative and hospice care, and died at home with her sister and niece. But even with that support, her final days were difficult. Her sister wrote to me:

> "she was highly distressed, everyday she said she'd had enough and wanted to die—it was very undignified for her and it was heartbreaking to observe but be powerless to help."

Each story we hear of loss and grief is unique. As legislators, we must consider everyone who will be affected, both directly and indirectly, by a change in the law. The public and the courts are rightly looking to Parliament to answer the question of whether the provision of assisted suicide should be a legal option. It is incumbent on us as parliamentarians to do the job properly.

Like many other Members, I have spent the past weeks listening to constituents and professionals in my Shipley constituency and experts in this place. I have read numerous reports and articles. As well as the moral and ethical dilemmas, there are many complex legal and practical considerations that need careful examination. I take a different view from the right hon. Member for Goole and Pocklington (David Davis), who has just spoken. I welcome the reassurances from my hon. Friend the Member for Spen Valley (Kim Leadbeater) and her

[Anna Dixon]

commitment that the Bill Committee should take evidence, but I am not confident that a private Member's Bill process will be able to adequately address the issues. That is why I have co-sponsored the cross-party amendment, tabled by my colleague the hon. Member for Runnymede and Weybridge (Dr Spencer), to call for an independent review and a systematic public consultation on these legal changes and for an independent assessment of the provision of palliative care.

With a background in health and social care, and specifically in ageing, I am particularly mindful of the context of the Bill and I wish to make three brief observations that concern me. First, we have heard many times about inequalities in access to palliative and end-of-life care. According to Hospice UK some 100,000 people die each year who could benefit from end-of-life care but do not receive it. Those who are non-white and from lower socioeconomic backgrounds are less likely to get care. Unless terminally ill people are confident of access to high quality end-of-life care, how can they make an informed choice about assisted dying? I believe that investment in palliative care must come before a change in the law is implemented.

My second point is about the failure to reform social care. Some people have to spend their life savings, including the value of their home, on care. Much of the responsibility for providing care falls to family members who fill the gap. Older and disabled people with a terminal illness may feel an unspoken pressure to go down the route of assisted dying to protect their inheritance, or because they do not want to be a burden. There is a real, direct risk of coercion. Annually there are 400,000 cases of domestic abuse against older people in England and Wales.

My third concern is that the NHS is on its knees, as outlined in the Darzi report, and an impact assessment is needed to understand fully the cost of implementation to the NHS. Do we have the doctors? What additional training is required? What is the opportunity cost of the necessary but lengthy process of establishing consent, capacity, and absence of coercion? Without that we risk making dying legal, but finding that it is available only to those who can pay.

I will conclude my remarks, respectful of the fact that many colleagues want to speak. I recognise that people can benefit from a potential change in the law—people such as my friend Sharon, for whom palliative care was unable to relieve her suffering. However, there are also many who could be put at risk by a change in the law, and other direct and indirect costs and consequences that need to be weighed up. I believe we should adopt the precautionary principle in this case, and without a proper public consultation and a detailed examination, I will be unable to support the Bill today.

12.21 pm

Carla Lockhart (Upper Bann) (DUP): Like many others across the House I come to this debate with personal experience. Many of us have been at the bedside of a loved one as they have neared the end of their life. For me that was on 11 June 2023, when my dad's earthly journey ended. Terminally ill for five years with a painful, aggressive cancer, he had a faith that sustained him and a health service that sought to support, care, comfort and preserve his life. Consultants and medical staff went over and above to ensure that he got every opportunity to see his family, and particularly his grandchildren, grow up. Did I want to see my dad suffer? Absolutely not. Equally, though, those difficult times provided us with an opportunity to care for and express love for a person whose life we valued.

The root of my conviction is this: life in all its forms is of inherent worth and value. While I have come to that conclusion partly because of my faith, like all Members across the House I have listened carefully to the evidence in coming to my conclusion on the danger that this Bill represents. Each individual person is of extraordinary value, not because of their capacity, intelligence or appearance, or for any reason other than that they are human.

It is right that we should rage against death, with its suffering and pain, as it is not natural, but the Bill takes that rational fear to an irrational and dangerous conclusion. The answer to a fear of death or of dying badly, or even a desire for a good death, is not logically to legalise a means of bringing about death in a more efficient or sanitised state-sponsored fashion. We are having the wrong debate today. We should be debating how as a society we can improve an individual's end-of-life experience through improved investment in end-of-life and palliative care, and the very best medical or hospice facilities. I strongly support efforts to that end, to improve how we provide for those who are suffering in their final months of life rather than seeking to end their life more quickly than is necessary, as this Bill does.

Tragically, at the moment one in four people do not have access to the care they need at the end of life. Many are unable to see their GP and get the pain medication they need as they face their last few months. It is a broken system, and one that the Government have pledged to fix. Surely that should be the priority, rather than introducing a state service that ends life. We need to debate how to properly fund the healthcare system we have, but the Bill would halt that debate and divert much-needed funding for better palliative care into ending life, not preserving it.

The Bill undermines the foundation on which our NHS is built—to preserve and protect life. It is not about individual pain; it is about a societal change that would end and devalue lives. It puts at risk the lives of vulnerable and marginalised people across our communities, with wholly inadequate safeguards against coercion. As has been the case in every country where such legislation has been introduced, it would see the rapid expansion of eligibility criteria, and it cannot protect against the unreliability of a terminal diagnosis. When we look at the complications of the drugs used in places such as Oregon, we see that it would not guarantee a good death.

Death is final. Today I have stood up for what is right, told the truth and warned of the dangers of this rushed and ill thought out Bill. I urge the same honesty from those who support it. This Bill is not the answer to end-of-life care, and that is why I and my Democratic Unionist party colleagues will vote against it.

12.26 pm

Rachel Hopkins (Luton South and South Bedfordshire) (Lab): I am glad to have the opportunity to speak in this hugely significant debate, and as a co-sponsor of the

Bill to support my hon. Friend the Member for Spen Valley (Kim Leadbeater) in advocating choice at the end of life. Since I came into this place five years ago I have spoken many times about assisted dying and the desperate need for reform of the law, and I believe this Bill is a landmark opportunity to change the status quo once for all, so that mentally competent terminally ill adults have the right to choose a peaceful, safe and compassionate death.

We hold a responsibility in this place to legislate for all people across the United Kingdom—for society. The overwhelming opinion of the public is clear. A poll conducted earlier this year found that 75% of people would support a change in the law to make it legal for terminally ill adults to access assisted dying in the UK.

The current blanket ban on assisted dying forces terminally ill people to suffer against their will as they near the end of their life, while loved ones watch on helplessly. Some choose to avoid that fate and seek assisted death abroad, but that comes at a substantial cost of around £15,000 to travel to Switzerland for that purpose. That highlights systemic inequality, whereby only those with the necessary financial means have access to a choice over the timing and manner of their death.

Dr Arthur: Will the hon. Lady give way?

Rachel Hopkins: I will continue, I am afraid.

As a humanist, I believe we have but one life and that we should live it well and make it meaningful. I believe that individuals should have autonomy in life. Similarly, I believe that at the end of life every person should have agency and the right to die with dignity and to a safe and painless death, on their own terms, subject of course to strong safeguards. I believe that the Bill contains stringent safeguards.

Although my humanist beliefs have contributed to my view, personal experience when young sparked my initial questions about the manner in which our lives end. My grandfather, Harold Hopkins, was an optical physicist and is remembered as one of the most innovative scientists of modern times. Many of his inventions are in daily use throughout the world, including zoom lenses, coherent fibre-optics and rod-lens endoscopes, which revolutionised modern keyhole surgery.

Unfortunately, my grandfather was not immune to the grip of a cruel terminal illness, and he sadly suffered greatly in the final weeks of his life, while battling prostate and secondary cancers, rendered blind during his final days, which was a cruel irony for a man who did so much to advance optics. But it was the haunted look on my father's face when he arrived home having spent the final few days with Harold, who was in terrible pain and suffering before he finally died, that had a lasting impression on me. Surely, in a modern society, if we are able to live a good life, we must be able to have a good death.

My grandfather was just one of many who have faced such a fate. I have heard from many constituents and from other families—many who are here today—who have shared their own stories of watching their loved ones die in unnecessary pain and indignity. While many have raised concerns around the need for better funded and supported palliative care services in our country, I reiterate the point that the Bill does not represent an either/or proposal.

As my hon. Friend the Member for Spen Valley has said over the past few weeks, at its core this legislation is about not ending life, but shortening death. This is fundamentally an issue of dignity, compassion and humanity, and I encourage all Members across the House to use their power as elected representatives to alleviate the needless pain of thousands of individuals and their families by taking the first step towards providing choice at the end of life by legalising assisted dying.

12.30 pm

Alicia Kearns (Rutland and Stamford) (Con): To discuss matters of life and death is to recognise the gravity of one's role as a Member of Parliament. The Bill before us seeks to shorten the suffering of the terminally ill—those with just six months to live—and no one else. For too many, death is not a singular moment but an excruciating journey of terror and agony as your body turns on you.

Arguments that we must wait for palliative care to improve in our country are a logical fallacy. The Bill does not prevent us from improving our palliative care system, contrary to what has been said today in the Chamber. In evidence to the Health and Social Care Committee, Hospice UK said that:

> "it would be totally inappropriate for us to suggest or even imply that hospice and palliative care services can somehow address…pain in all circumstances."

Imagine you have cancer that day by day is breaking every individual vertebra in your body, one by one, and there is nothing that can take away the pain—that is how my mother lost her life. Her last words were, "I cannot go on like this," and, thankfully for her, there were only a few more days of pain; however, for others, there will be months more. Before they get to that six-month period, people will have suffered years of excruciating agony that palliative care cannot resolve. Yes, we must improve palliative care, and I will fight for that.

Arguments that this legislation would be the beginning of a slippery slope are not reflected by the majority of legislators, such as Australia and across multiple states in the USA, where such policies have not been expanded. Again, the Health and Social Care Committee has told us that where terminal illness was the basis—not suffering—as for this Bill, the law has not changed.

As a Conservative, freedom, choice and personal responsibility shape my decision making—until those freedoms cause harm to others. I do not see the role of legislation as imposing moral convictions. It is our job to protect choice. I say to those whose religious beliefs drive their arguments today that I will always defend their right to practise their faith and protect their own life choices. However, supporting the choice of others does not diminish the principle of compassion; it recognises respect for individual autonomy. To deny choice to others—especially those with only six months to live, where their personal choice does others no harm—is wrong.

To those concerned about the state mandating powers to decide who can and cannot live, I say that judges already exercise this power. They end lives in far more complicated cases, such as those of children on life support.

[Alicia Kearns]

On arguments around procedure, we all have to be honest with ourselves: this Bill has been read far more vociferously than most Bills that go through this House. Most Bills over the past 20 years have come to Parliament with far fewer than 14 days to consider them: for the Police, Crime, Sentencing and Courts Bill, we had six days to consider 59 pages; for the Illegal Migration Bill, we had six days to consider far more. We have had sight of this Bill for longer than many others. The idea that a private Member's Bill is not appropriate is also wrong. Social reform comes through private Members' Bills: the abolition of the death penalty, the legalisation of abortion and the decriminalisation of homosexuality—all things I hope this House would unite on.

This is the start of the process of debate, and it would be a tragedy if the Bill were defeated today. Members should trust me when I say that I learned early in my career that when we hear promises that things will come later, that is a promise that no action will come at all. The High Court made it clear to my constituent Phil Newby, who has motor neurone disease, that we must make this decision. To those considering abstaining because this is so difficult—and I recognise that it is difficult—I say that we must not shy away from it. I ask colleagues to vote for the Bill in order to allow a long legislative process to proceed and, together, to commit to shortening the suffering of those who are terminally ill in our society, because they deserve that choice.

12.34 pm

Paulette Hamilton (Birmingham Erdington) (Lab): I congratulate my hon. Friend the Member for Spen Valley (Kim Leadbeater) on the way she has conducted this debate. I worked in the NHS as a district nurse for 25 years, working with many terminally ill people. I saw the whole range of human emotion in that time, from joy to grief—everything imaginable. I am also a mum, a daughter, a sister, a wife and a grandmother. I know how crushing it can be when someone we love is terribly ill and how helpless that can make families feel.

It is completely understandable that some would want to feel that they are regaining some control over their circumstances by pursuing an assisted death, but this Bill is not the answer. I simply do not trust that it can be implemented ethically or safely. There are too many blind spots, and it is being rushed through too quickly and with too little scrutiny. It would place enormous pressure on disabled, elderly and poor people to opt to end their lives so as not to be a burden on their loved ones.

The Bill would also do nothing concrete to uplift the hospice and palliative care sectors. All that we have had are promises. According to the Bill, the Secretary of State must ensure that assisted suicide is available. There is no accompanying duty to provide palliative or hospice care to everyone who needs it, leaving those essential services heavily dependent on donations and charity. That is simply unacceptable.

The exercise of coercion or pressure, which are prohibited by the Bill, is difficult—perhaps even impossible—to detect. Families and personal circumstances are complicated. It would take an enormous amount of resources to make this system robust enough to entrust the lives of our loved ones to it. The Bill allows doctors to propose assisted dying to patients. Some of the worst Canadian abuses originated that way. For example, a 51-year-old Canadian cancer patient was notoriously offered death instead of surgery. Even though our proposed system has its differences, this is still a risk that I am not willing to take.

The current law presents us with a clear boundary that can never be crossed. It avoids all slippery slopes, with no room for error. Assisted suicide legislation would replace that with an arbitrary boundary that is rife for misunderstanding, error and, at worse, abuse. Remember: this is all happening in the context of an NHS run into the ground by 14 years of Tory austerity, and the Government have simply not had the time to rectify it. It is not a fair choice as a result.

I will therefore be voting against the Bill and will continue to push for improvements in palliative and hospice care. That is the only way to ensure that no one from any community is left behind.

12.38 pm

Sir John Hayes (South Holland and The Deepings) (Con): I have known well only one person who committed suicide: my former professor. I learnt after his death that he had been haunted by imagined demons for most of his life and, in the later part of his life, hounded by heartless humans. Had assisted suicide been available to him, I am sure that he would have died much earlier. After those demons first visited him, he had a loving wife and three daughters, so he had moments of joy, though most of his life was punctuated by pain. I am just as sure, because I knew him well, that he would have voted against this Bill today, for all our lives are a mix of sorrow and joy.

I will not amplify the arguments about process, although I think it is immensely naive to assume that this Bill could be changed substantially in Committee. As a shadow Minister and a Minister for 19 years, I oversaw many Bills in Committee, and I know what Committees do. They calibrate, refine and improve legislation; they do not fundamentally alter the intent voted for on Second Reading.

Neither shall I talk too much about what happens in other jurisdictions, except to say that it is certainly true that everywhere it has been introduced, assisted dying has expanded—not always by subsequent legislation, but often through judicial interpretation. The idea that we should put this charming but rather naive faith in the judiciary to make these decisions subsequent to the House passing the Bill is just that: innocent—that is the most generous way I can describe it.

What I will talk about is simply this: the Bill would change the relationship between clinicians and patients forever. It would say to the NHS, "Your job is not only to protect and preserve life; it is sometimes to take life." I am not prepared for our NHS to be changed in that way. Beyond that, the Bill would change society's view of what life and death are all about. This is not just about individual choices, as hon. Members have said in their interventions and speeches; it is about a collective, communal view on how we see the essence of life and death.

Finally, we have had a civilised debate in this place, but it is very different out there on the mean streets, as each and every one of us knows. There are many cruel, spiteful, ruthless and unkind people in the world, and there are also many vulnerable and frail people. When those two groups collide, the outcome is not good for the second.

I fear this Bill. I will vote against it. I will vote for what a politician in another place once called "the audacity of hope"—hope that we can improve palliative care; hope that we can do better. I fear for the disabled and vulnerable people who would be affected by the provisions of this Bill, which—regardless of the good intentions of its advocates—I believe will fan the flames of fear.

12.42 pm

Jake Richards (Rother Valley) (Lab): I welcome the contributions to this debate from all sides of the House. This is Parliament at its best. I support the Bill and am proud to co-sponsor it. We have all received emails from constituents with harrowing stories of the agonising final days and weeks suffered by loved ones. I have no doubt that those stories will weigh heavily on each of us, however we vote today.

Fundamentally, I believe that if we are able to safely offer peace and empowerment to those at the end of their life, then we have a moral imperative to do so. We are lawmakers, and I also fundamentally support this change because our current legal framework is simply not fit for purpose. Our criminal law is a mess. Four former Directors of Public Prosecutions have told us that change is needed. It is pretty unprecedented for four former Directors of Public Prosecutions, the sole people who make decisions about prosecutions in such cases, to urge Parliament to take action.

In the 2014 Nicklinson judgment, the Supreme Court urged Parliament to take action because the law was not working in this area. The law is chaotic, particularly in how it relates to the argument around coercion. If we vote against this legislation today and it falls, do not think that vulnerable people at the end of their lives will not be subject to coercion this weekend and over the coming weeks. The police will investigate, a coroner will undertake an inquest into the circumstances of any suicide and a prosecution may begin, but all these processes will occur after the individual has died. This Bill would shift the emphasis of such inquiries to before the event, which is more logical, more rational and more humane.

Let me quickly deal with the procedural argument. As the hon. Member for Rutland and Stamford (Alicia Kearns) mentioned, private Members' Bills were sufficient to reform our abortion laws, abolish the death penalty and change our divorce regime, and a private Member's Bill was good enough when the issue was last before the House in 2015. I have read every single word of that debate, and there was not a single word of opposition to a private Member's Bill being the mechanism for such change. Since 2015, there have been Select Committee reports and more evidence from around the world, as other jurisdictions move in the direction of assisted dying. One begins to wonder whether opponents to change are grasping at procedural straws, rather than taking on the principle, as we should at Second Reading.

I appreciate that the decision is difficult for colleagues and I respect views on all sides of the debate, but these moments do not come around often. I urge colleagues to seize the moment, shape the world around us and provide for compassion.

12.45 pm

Sir Julian Lewis (New Forest East) (Con): In the past I have voted against this type of measure, and for one overriding reason: namely, the impracticability of effective safeguards. Even if practical safeguards could be erected against external coercion, I have always felt that there was no prospect whatsoever of having effective safeguards against internal pressures on someone to request assisted dying or even euthanasia.

For example, as we have heard, an elderly person in a care home, knowing that the legacy they could bequeath to their children was being reduced by tens of thousands of pounds every few weeks, would be highly likely to feel obliged to ask to die. I cannot conceive of any safeguard against self-sacrifice of that sort, whether for financial reasons or in order no longer to be a burden on one's nearest and dearest relatives and friends.

However, there is an additional point that I wish to inject into the debate. In my opinion, the key to this dreadfully difficult conundrum—about end of life care, pain and the possibility of assisted dying—lies, or should lie, in the ability of medical personnel to administer effective pain relief even if it shortens the patient's remaining time. In my view, there should be no bar on the use of painkilling medication, if that is the only way to ease human suffering, even if it leads to a speedier death—hence the frequent references to putting dying people "on an appropriate pathway."

It was therefore most alarming to me to read a very important paragraph in a letter sent to me in favour of changing the law and voting for the Bill by my constituent, the distinguished broadcaster Dame Esther Rantzen, in which she explains that doctors no longer feel able to follow this humane course of action since the atrocious Harold Shipman case, which was briefly alluded to by my right hon. Friend the Member for Goole and Pocklington (David Davis). If there has been such a change in regulations, as Dame Esther believes, it is imperative that that should be reversed. That is something positive that could come out of the imminent debate.

Another issue that has been touched on more than once is the uncertainty and the postcode lottery surrounding effective palliative care. Dame Esther's view is that there are some people, who have some conditions, for whom palliative care never can be effective. Other people expressed the view that there is always a way in which painkilling medication can be used in order to prevent suffering. I suspect the answer to that riddle lies in the fact that that painkilling care, in some cases, might lead to a shortening of life.

Therefore, I conclude that there are three issues that should be in our minds. Can safeguards be effective? My answer to that, I am sorry to say, is still no. Can pain be alleviated sufficiently by palliative care? The balance of the argument is in favour of saying "probably yes", but it is too uneven across the country and would certainly need the sort of investment that would be necessary to set up system that would work for assisted dying. Above all, have doctors the freedom to administer pain relief that may shorten life? We need to know the answer to that question, because if, since Shipman, they have been prevented from taking such merciful measures, that is a classic example of hard cases making bad law. Doctors need to be able to humanely ease people on

[Sir Julian Lewis]

their last journey, and the country needs to know where the medical profession stands on that central matter to this debate.

12.50 pm

Jess Asato (Lowestoft) (Lab): After spending almost a decade working to protect women and children from harm, my focus with any piece of legislation is the potential it creates for abuse and coercion. While I would once have been supportive of the principle of assisted dying, and might wish that option for myself, I have been increasingly unable to reconcile my desire to safeguard the most vulnerable with putting that principle into practice. I am concerned that if the Bill passes we will see people coerced, either by an abuser or by societal expectation, into ending their own lives.

We do not want to think about it, but abuse surrounds us—2.3 million victims of domestic abuse in the last year. One in six older people experience abuse. The definition of coercive and controlling behaviour includes behaviour that repeatedly puts someone down, telling them they are worthless. Victims describe this as a "drip, drip" effect, and it goes unnoticed. Not just because we do not want to think about it, but because it is hard for professionals to identify it without proper training and with the lack of specialist support. There is no mandatory training for judges on coercive and controlling behaviour, nor is there effective training for medical professionals. In a 2019 survey, 50% of healthcare professionals said that they did not feel they had received adequate training to identify a victim of domestic abuse.

It is also hard for victims themselves to realise they are being coerced until they have got free. We know that older people, especially those who are disabled, are particularly susceptible to abuse by a family member and less likely to be able to escape their abusers. Those who are coerced are often isolated from friends and family. If people are not required to tell friends and family they are opting for assisted dying, who will raise the alarm? How would any concerns be reported? Will judges be able to investigate the police records of those around a person who has requested assisted dying—family or carers?

I will always remember a conversation I had with a hospital-based independent domestic violence adviser, who was called to the bed of a lady in her 80s in her last days living with cancer. The lady disclosed to the IDVA that she had been abused by her partner of 50 years, and said "Thank you. I have never told anyone before, but now I am finally free to die, and I am grateful for the release."

We know from the Monckton-Smith report that a third of female suicides could be linked to domestic abuse, and from the Killed Women campaign that as many as 130 women each year could be murdered by a partner or relative but have their deaths are recorded as suicide or accident. Every week, we hear of family court judges failing to spot coercive and controlling behaviour. In one case, a judge found that a man repeatedly calling his partner worthless and telling her to die was not controlling conduct.

Where is the discretion of gender in the Bill? Out of 60 documented cases around the world of euthanasia and assisted dying for people with anorexia, 100% were women. I have come to the view that no Bill, however drafted, could adequately sift those with a genuine desire to end their own lives from those doing it for all the wrong reasons. For that reason, I will vote against.

12.54 pm

Siân Berry (Brighton Pavilion) (Green): I thank everyone who has spoken so far. This has been a very respectful debate, and I do not think any of us here have not shed tears at the messages that our constituents have sent us this week. I have received so many profoundly moving letters, postcards, emails and other messages sent to my office, and numerous people have told me about their personal experiences of loved ones facing really hard choices at the end of their lives. It is very moving. This is a big decision for us.

Well-informed public opinion shows that a very large majority of people want the option to choose assisted dying in the circumstances envisaged by the Bill, and this level of public support reflects the fact that the law, as it stands, too often forces people to endure horrific deaths. I have heard so many stories from constituents of the trauma and pain that they have witnessed in loved ones. Too many people are affected by the current law in truly painful ways, and too many of those who are able to do so now seek unregulated, distressing and unsafe alternatives, because there are no legal options. Those who wish to end their lives at the point when their suffering from a terminal illness becomes unbearable may act too soon. They may take their own lives, and do so before they reach a point at which they require assistance—in secret, leaving a legacy of shock and confusion, instead of peacefully planning an ending to their final few months. Some of the testimony that I have seen from family members and partners who face the consequences of these secret decisions are truly heartbreaking, because the current law also makes it a prosecutable offence for anyone to advise or assist someone in this horrible situation in any way, thus putting at risk anyone who even knows.

Several people have also raised concerns about coercion with me, and I have listened very hard. I aim to cast a vote today that will protect people better. The hon. Member for Rother Valley (Jake Richards) made, very well, the point that the Bill will be a clear improvement on the current law in respect of safeguards against potential coercion for terminally ill people, and we should all listen to that argument.

Like the hon. Member for Gower (Tonia Antoniazzi), I do have one constructive point to make. I think we should be discussing it during the Bill's ensuing stages, which I hope we will vote for. It concerns the time limit. Other jurisdictions already allow for different time limits, or no time limits for terminally ill people, or a separate time limit for a number of well-known, specific neurological diseases, in which the period of terrible suffering can be much longer than six months.

Gideon Amos (Taunton and Wellington) (LD): Will the hon. Lady give way?

Siân Berry: I am sorry, but I have no time.

Like many other Members, my colleagues and I have heard many concerns expressed about the availability of palliative care. I hope that we are seeing the start of a much more open conversation about the practical problems that people face at the end of their lives—something we are generally not comfortable with talking about in this country—and about the provision that we do not currently make for people in anything like an adequate way. We must do better and, like other countries, make sure that we see improvements in palliative care at the same time as making this change. While we do not have to choose between the Bill and better palliative care, we do have to give dying people the right to choose which ending is right for them, so please, please, vote for the Bill today.

12.58 pm

Lizzi Collinge (Morecambe and Lunesdale) (Lab): I thank Members on both sides of the House for the care and consideration that they have given to this debate. If the Bill is given a Second Reading today, there will be further lengthy scrutiny, but I want to address what I think is a bit of a misconception about it, namely the ideas that patients taking the decision to die and doctors assessing capacity, coercion and consent are somehow new. We have heard the word “Rubicon”. There seems to be an idea that this is a completely new sort of decision, and that this is something unusual and outlying in medical practice. I want to challenge that, because, actually, patients, doctors and indeed High Court judges are already making life-and-death decisions every day. As my hon. Friend the Member for Bury St Edmunds and Stowmarket (Peter Prinsley) said, in this case we are actually talking about death-or-death decisions.

Let us take the example of withdrawal of treatment. One of my close family members who would not be covered by the Bill’s eligibility criteria starved herself to death through withdrawal of treatment. She had been unwell for many decades with a condition that would have eventually killed her. At one point she became unable to swallow. For many years she had relied on artificial nutrition, and when the type of artificial nutrition she needed changed to a more invasive process, she said, “Enough’s enough.” As a mentally competent adult under the current law, she was able to take that decision. People are already legally able to die early through withdrawal of treatment. I emphasise that she would not have been eligible under the criteria of the Bill, and I have no idea what she would have chosen if she had had a choice, but the fact remains that her capacity was assessed by a doctor and she was allowed under the current law to die early.

The BMA has told us that it regularly assesses for capacity, coercion and consent in, for example, abortion care and—as in the example of my relative—dying through withdrawal of treatment. The Bill and the safeguards it would put in place would give a stronger framework of protection than the existing law.

Under the Bill, two doctors would have to test for capacity, coercion and consent. That would have to be reviewed by a High Court judge and pauses for reflection are built into the process. If it does get to the point of an assisted death, the patient themselves must administer the approved substance.

Let us be clear about who the Bill is for. The eligibility criteria are extremely narrow—some have argued that they are too narrow. The Bill is for mentally competent adults who are nearing the end of their lives. They are dying, and they are dying soon.

Many people with a terminal illness will have a perfectly ordinary death managed perfectly well by palliative care. But we have heard in recent weeks—over many years, in fact—about the people who do need the Bill: the people for whom even the best palliative care simply does not work; those for whom merely the option of an assisted death gives them peace and comfort and a chance to enjoy the rest of their lives without fearing the manner of their death. With the safeguards contained in the Bill, who are we to deny them that peace? Who are we to decide what they must bear as they die?

We have the power through a robust legislative process to prevent human suffering. Good palliative care and assisted dying are not at odds. They are not in conflict. They both aim for the same thing: a good death, surrounded by people you love, with minimal pain and without fear. Today, we can vote for that in the sure knowledge that if the Bill passes its Second Reading, it will undergo further intense scrutiny to ensure that it is a good law that works as it is intended to do. This is the start of a legislative process, not the end. I urge colleagues across the House to vote yes.

1.3 pm

Robert Jenrick (Newark) (Con): I want to talk about two aspects of the Bill: what it could have done in terms of safeguards but does not; and what it does not do but could never resolve. On the first point, the safeguards—in particular the legal and judicial ones—are grossly inadequate. Bad law on trivial things is bad enough—I have seen a lot of that in my time in the House—but bad law on matters of life and death is unforgivable.

We have spoken about the role of doctors; let us think about the role of judges. The test to be applied is a low one: the civil law threshold, which is a balance of probabilities. This means that a judge could see real risk of coercion and still sign off an individual for assisted death. If the threshold of 50% or more was not reached, the judge would sign off the individual. The next of kin is not informed. There is no right of appeal, which is extremely unusual in English law, and the process is conducted in secrecy. It could be done on papers alone. Transparency is critical to the law. It is one of the oldest principles in our English legal system. As Jeremy Bentham said more than a hundred years ago, evil can arise in secrecy, and publicity is at the heart of justice. This is not a transparent process and that leaves it woefully open to abuse.

Secondly, all of us in this House want to believe that the laws that we pass are final, full stop, the end. That is not the case. I worry—in fact, I am certain—that as night follows day this law, if passed, will change; not as a result of the individuals in this Chamber or the other place, but as a result of judges in other places. We have seen that time and again. It may be on either side of the debate, but it will happen. If passed, the Act will be subject to activist judges in Strasbourg. They will change it fundamentally and we have to be prepared for that. I do not want to see that happen.

My last point is not about how we can improve the Bill; it is about something that we can never resolve as a House. The Bill is not so much a slippery slope as a cliff edge. When we walk out of this Chamber, or out of the gates of this building tonight, we will, in a way, walk into a different country if the Bill passes. There will be

[Robert Jenrick]

different conversations around kitchen tables. There will be different conversations had by couples lying in bed at night, or on quiet country walks where people talk about difficult things. They will not be conversations that make our country a better place.

More important, there will be people who do not speak about these things at all. There will be imperceptible changes in behaviours. There will be the grandmother who worries about her grandchildren's inheritance if she does not end her life. There will be the widow who relies on the kindness of strangers who worries—it preys on her conscience. There will be people—we all know them in our lives—who are shy, who have low self-esteem, who have demons within them. I know those people. I can see them in my mind's eye. They are often poor. They are vulnerable. They are the weakest in our society. And they look to us, to Parliament, to represent them, to support them, to protect them. In their interests, I am going to vote against the Bill today. Sometimes we must fetter our freedoms. We the competent, the capable, the informed sometimes must put the most vulnerable in society first.

1.7 pm

Florence Eshalomi (Vauxhall and Camberwell Green) (Lab/Co-op): I start by commending the hon. Member for Runnymede and Weybridge (Dr Spencer) for outlining some of the complications with the legislation as it stands. I also put on record my admiration for my right hon. Friend the Member for Birmingham Ladywood (Shabana Mahmood), who has, in my opinion, been disgracefully singled out in comparison with others for her view of the Bill.

The Bill could be the most consequential piece of legislation that has been considered during my time in this House, and is at the heart of the matter of why I came into politics. Many Members have spoken about coercion and about providing a voice for people who often do not have one. It is that principle which has guided my decision to oppose the Bill. I know there are sincerely held beliefs on both sides of the debate. They can seem completely at odds with each other, but it is my firm view that everyone speaking today shares the same goal: a more compassionate society in which everyone can live and die with dignity. But true compassion should have equality at its heart. It is for this reason that I cannot support the proposals as they stand.

We must recognise the hard truth that health inequalities are wide and persistent. We know that black and minority ethnic disabled people have far worse health outcomes than the national average. I saw that at first hand when caring for my mother, who suffered with sickle cell anaemia. As a teenager, I would be by her side when she was in excruciating pain, explaining to a doctor who would not believe her when she told him that she needed life-saving medication. Sadly, that is still the reality today. I am reminded of the death of Evan Smith on 25 April at North Middlesex university hospital. Evan suffered from sickle cell too. He was in so much pain that he had to ring 999 from his hospital bed, because he was denied oxygen and basic care by the doctors. Put simply, we should be helping people to live comfortable, pain-free lives on their own terms before we think about making it easier for them to die.

Colleagues will be aware of clause 15 of the Bill, which outlines the provision for signing by proxy. I am worried that this could create issues for vulnerable groups who are more prone to coercion by family members. As many Members have said, assessing beyond doubt whether someone has been put under pressure or coerced would be difficult. If this legislation is passed, even the legal experts seem to be in disagreement on this, so I do not believe that there has been enough scrutiny. The risk of coercion will be highest for some of the most disadvantaged people in our communities. As a society, we risk pushing people to seek an early death. I cannot, in good conscience, support this.

My late mother lived with chronic illness all her life, and I knew that one day her pain would be too unbearable for her, but she did not let that limit her. She wanted to live. I do not believe that the Bill would protect the wishes of people in her situation, because freedom in death is possible only if we have had freedom in life. How can we possibly be satisfied that this Bill will deliver equality and freedom in death when we do not yet have it in life?

Madam Deputy Speaker (Ms Nusrat Ghani): If colleagues continue to work with me, I will try to get in as many people as possible.

1.12 pm

Liz Saville Roberts (Dwyfor Meirionnydd) (PC): Diolch yn fawr iawn, Dirprwy Llefarydd.

I think the starting point for many of us today is how to resolve the dilemma of what we want for ourselves against the fear of enabling potentially terrible consequences for others. There is a rational fear of the reality of coercion, what drives decisions within families and what individuals feel is best for their family. There is a rational fear of how institutional pressures, lack of resources and, appallingly, the culture in the NHS might ramp up the convenience of death as an affordable option. This is not a new fear. The hon. Member for York Central (Rachael Maskell) mentioned Baroness Neuberger's review of the Liverpool care pathway, which said:

> "In order that everyone dying in the acute sector can do so with dignity, the present situation has to change."

That was in 2013. We know, in the aftermath of covid, how little has changed.

Death as an institutional convenience has never been, and never will be, right. It is our duty to demand good palliative care and address the institutional and resource barriers to it, but that is not a licence to sidestep today's moral question. The people of England and Wales now expect us as legislators to provide an answer in principle. It is our duty to provide that answer not only in principle, but in process. With that in mind, I will support the Bill on Second Reading if there is a guarantee of sufficient scrutiny to stitch together a complete garment out of what is presently threads and patches that could, as we have heard, be rent asunder in court. If Committee scrutiny cannot make the Bill robust, I will reconsider my support in future votes. Surely this House can ensure that there is both cross-party and small-party representation on the Committee, rather than conventional party proportionality—of course, today we have a free vote.

The implications for Wales, where health is devolved, cry out for proper consideration. I support the hon. Member for Gower (Tonia Antoniazzi) in her concerns about the Sewel convention and the need for a legislative consent motion in the Senedd. These concerns are equally true not just for Wales but for remote and deprived communities where ill and dying people already suffer disproportionately inadequate health services.

To close, I credit Iola Dorkins of Morfa Nefyn whom I have known for over 30 years and who is presently dying of motor neurone disease. She wears a brace that her husband has adapted to make more comfortable. Today, she is on respite in a hospice in Holyhead, which is 50 miles away from her home. That is the reality of people's lives as things stand. We need a change in the law.

1.15 pm

Dr Simon Opher (Stroud) (Lab): I am one of those medical practitioners, sometimes known as a doctor. I have been a GP for 30 years, and every year I look after four or five cases related to palliative and terminal care, so I have a lot of experience in this area.

I would like to make some quick observations. First, a lot of patients who are dying of cancer ask whether we can curtail their life and finish it a bit early. That is a very common thing that they ask. I have had two patients go to Dignitas on their own, without family members, because the family members were fearful that they would be arrested on their return. We have been discussing giving a double dose of morphine. I think that almost all doctors in terminal care have probably done this—doubled the dose of morphine knowing that it might curtail the patient's life. That is a big fudge. It puts me in a very vulnerable position. We need to resolve that.

I think we are getting a bit confused between palliative care and assisted dying. A lot of people who receive excellent palliative care still request assisted dying. They are not mutually exclusive. I totally support what everyone is saying about developing palliative care, because that is really important, but that should not go instead of assisted dying. The things go together. Assisted dying is one of our tools in palliative care, as I see it going into the future.

I have a couple of points about coercion, which people like me need to assess. If someone says that they feel like a burden, that is immediately not a good reason to approve assisted dying. Doctors are trained in assessing capacity, as has been said, but we are also trained in trying to find out the reasons someone wants to end their life. I think it is judging doctors harshly to say that they will not spot coercion. Interestingly, the only change in Australia was that they found that the judiciary review did not add much to the process. Otherwise, there does not seem to be a slippery slope, as long as the legislation is carefully done.

Joe Robertson (Isle of Wight East) (Con): The hon. Member opened by referring to himself as a doctor and medical practitioner. Perhaps he could help with the difficulty I have with the Bill, which I would dearly like to support. There are provisions in it that allow the Secretary of State to bring forward regulations so that the independent doctor can be an alternative medical practitioner. There is also a section that makes the court look like an optional process, so I do worry that there are not protections in the Bill for two doctors. Perhaps he could help with that.

Dr Opher: I do think it is right for this Bill to require two doctors and a judiciary review, because this is new legislation and we must be sure that it is safe. These safeguards are incredibly important.

I will finish simply by saying that having been a doctor all my life, I have tried to empower patients to make their own decisions over their healthcare, and this is a great opportunity to do that. I had one patient who had a terminal diagnosis and hanged himself. The family were devastated. It was a horrible way to die. I felt that we had failed as a medical profession. Let us not fail as a Government, a judiciary and the Houses of Parliament. Please support the Bill.

1.19 pm

Dr Luke Evans (Hinckley and Bosworth) (Con): How do you want to die? How do you picture your own death? It is a question we rarely ask ourselves, but one that every one of us will face. For me, I hope it is with peace, surrounded by loved ones, free of pain and content with a life well lived. That is the gold standard. Good palliative care strives to make that ideal a reality.

Let me state unequivocally: we need to support palliative care. However, today's debate is not about whether we support palliative care, but about what happens when we cannot provide a solution. What happens when palliative care does not or cannot work? The truth is that palliative care has limits. Let us consider the cases that keep doctors and surgeons awake up at night—the likes of the inoperable neck cancer, eroding away into the carotid artery. It is a literal bloody time bomb, and no one knows when it will go off. What is modern medicine's answer to that? Keep dark towels nearby for the blood, and counsel a partner or family member on what it is like to find someone bleeding out. There is no cure, and no respite. What would you do?

Currently, for such patients we can offer no agency over their end; no alternative to that terrifying death. Can we truly say that that is compassionate? Should we not even offer those facing such suffering at least the chance of dignity in their death? That is what the Bill stands for. To reject it on Second Reading is not just to vote against assisted dying but to silence the debate for another decade and to say that the status quo is acceptable, and it is fine for those who can afford it to fly to another country to end their suffering while others are left here without recourse. I cannot accept that. What is this House for if not to empower people, and to give them the tools to shape their lives and, yes, their deaths? Today, we have the chance to put compassion into action—to offer choice to those who are facing the ultimate suffering.

I hugely respect Members who take a different view. I simply and gently say to them that there are consequences, too. Those intractable cases will still be there with no solution, no choice in this country and no resolution to their suffering. To those who understandably are a little unsure, I say that if they have doubts about safeguards or the implementation—I agree that some are valid—they should let the debate continue. For some Members it

[Dr Luke Evans]

will a bridge too far; if necessary they should reject the Bill on Third Reading, but to stop it now is to stop the conversation entirely, take the choice off the table and remove a dying person's agency. When all is considered, I ask again: how do you want to die?

1.22 pm

Mr James Frith (Bury North) (Lab): The Bill asks us to make a profound and irreversible decision on the principles of our health service and end of life care. With end of life care funded too often on a shoestring for many, the Bill takes our focus to ending life, not improving living as life draws to a close with terminal illness. I believe it poses significant risks. Our wider societal and cultural norms will be changed forever. Those who refuse to acknowledge that prospect now do so with the benefit of things as they are now. My point is that this concept changes immediately today if this Bill is passed.

The safeguards may sound rigorous on paper, but the strained state of our NHS means that many patients do not have a consistent relationship with a named doctor. We are attributed to health centres nowadays, not named doctors. Someone's consideration of this decision could depend on which doctor they see—one who raises assisted dying as an option, versus one who refuses. That is a deeply troubling prospect. The ideation of assisted dying will become a ballot. We know our GPs have a range of views on assisted dying, so we cannot deny that who someone ends up seeing with their terminal illness might be how they end up. That could be at the doctor's, possibly in the presence of a loved one who is under strain and in need of respite themselves, and the first suggestion is the beginning of a journey towards, yes, assisted dying. That is before we consider the forces of marketing and commercialisation, and the industry that will spring up if the Bill proceeds and is sewn into our NHS.

Neil O'Brien (Harborough, Oadby and Wigston) (Con): Will the hon. Gentleman give way?

Mr Frith: No, I will not.

It is possible that we cannot imagine being the victim of coercion, or that as MPs our agency is so baked in to our experiences of living, that we cannot envisage a scenario where those who already claim to feel unseen are directed towards meeting their end sooner than it otherwise might have been. Our casework from constituents is already full of people struggling to access the rights that we have enshrined in law—access to justice, health, education support, the disaster in our special educational needs system—and of victims often of state neglect or state coercion, and the failure of safeguards that were once supported on paper and passed into law.

Disability rights groups and advocates have raised their voices, wanting us to talk about the dangers of normalising assisted dying. For many the Bill represents not a choice but a principle shift that undermines the value we place on protecting the vulnerable. It falls to us as the strongest to stand up and vote against the Bill. Passing the Bill today will not improve palliative and hospice care. My belief is that it will forfeit it. The end of life is complicated; end of life care often is not complicated enough. On reflection, my mother-in-law deserved a frank, trusted conversation about the risk of secondary illnesses and amputation that would follow with the automatic cancer treatment that she was given in her final months of life. We should expect more agility from our NHS, and while dying is the ultimate binary experience, end of life care should be more sophisticated and more personalised. Shortening those expectations with a system that endorses assisted dying would forfeit that too.

Finally, as legislators our responsibility is to protect the most vulnerable and consider all eventualities. We disagree on slippery slope arguments, but if the Bill proceeds it will be a moment of no return, and that is why I am not prepared to support it.

1.27 pm

Dr Neil Shastri-Hurst (Solihull West and Shirley) (Con): It is a privilege to speak in this debate, and the way in which the House has conducted itself on both sides of the argument is a credit to this place.

I stand here not only as a medical practitioner who worked as a surgeon for about a decade, but also as a healthcare barrister, so I have looked at the debate from both sides of the argument. I have been deeply moved by some of the stories I have heard about patients who are facing a terminal illness. I am also instructed by my own experiences—my personal experiences of my relatives, and of those patients whom I failed. I failed because I did not give them the good death that they deserved, despite the very best efforts of palliative care.

It is true that we can improve the palliative care offering in this country, but it is not a binary choice. It is not a choice of palliative care or assisted dying; it is a choice about someone having an option over how they want autonomy over their body at the end of their life. I understand the concerns raised in this House—I genuinely do—but this is not the point to cancel the debate. This is the point to engage in the debate. This is the point at which we move it forward, so that people can contribute to it in Committee and say how things can be improved, and so that we can work together to make a societal change, improve our society and support those who want that ultimate choice in those last days.

1.29 pm

Paula Barker (Liverpool Wavertree) (Lab): I am honoured to rise to lend my support to the Bill, and I am proud to support my hon. Friend the Member for Spen Valley (Kim Leadbeater) as one of the Bill's co-sponsors.

Data shows that in my city of Liverpool 74% of people are in favour of assisted dying. I have been privileged to correspond with and meet so many of my constituents who have shared with me their views and personal stories, spanning both sides of this important debate, and I thank them all. As we have heard today, there are strongly held beliefs on both sides of the House. I absolutely respect those with views that differ from my own, and hope that they respect my views, even if we disagree.

Since long before I entered this place, I have been an advocate of assisted dying, with the appropriate safeguards, to alleviate unnecessary suffering. My own mum cared for my dad during his cruel battle with cancer. Sadly, not even the best palliative care could provide him with a good death—and I do believe that there is such a thing as a good death. At its core, the Bill is sensible, safe and compassionate. But above all else it places human dignity at its heart.

In respect of palliative care, the Bill is not an either/or. Along with many other campaigners for assisted dying, I fully support improving palliative care. It has been proven that end of life care has improved in several countries because of assisted dying reform. I hope that, if the Bill passes, the UK will also belong on that list. Palliative experts, including those opposed to law change, admit that some people's suffering is beyond the reach of even the best palliative care.

I do not believe that if the Bill finally becomes law, it will create a slippery slope. As the right hon. Member for Sutton Coldfield (Mr Mitchell) eloquently said, terminally ill adults in Oregon have had a legal option for assisted dying for more than 25 years, and not once has it been expanded to include other groups.

Gideon Amos: Will the hon. Lady give way?

Paula Barker: No. I am sorry, but I will not.

Every year, around 650 terminally ill people take their own lives, and countless others who are more affluent make the choice of the long, arduous journey to Switzerland, all without any protections in place. I do not want choice to be available only to those who can afford to pay. That is not just or equitable.

Finally, just like with many other private Members' Bills that have gone before and looked to bring about social reform—such as those on abortion, divorce and the decriminalisation of homosexuality—this is an historic moment and an opportunity, if taken, to give real dignity to those who have reached the end of life and want a choice, while also respecting the views of those who do not want to take that choice.

1.32 pm

Mr Peter Bedford (Mid Leicestershire) (Con): This is a humbling subject to speak about. I put on the record my thanks to the hon. Member for Spen Valley (Kim Leadbeater) for bringing this important issue before the House.

I have witnessed at first hand the cruelty that a terminal diagnosis brings. As the son of a single mother, my grandparents were like second parents to me. Each struggled with their own incurable cancer diagnosis. At Christmas dinner in 2019, my nan, who could no longer eat and was clearly in a great deal of pain, turned to me and said she was "ready to go". "It's time now," she added. That night, I reflected on how, as a society, we shy away from discussing death. We park it away and prioritise more immediate, palatable subjects, but it impacts members of our communities day in, day out— from terminal diagnoses to medical treatment and, ultimately, their final days. This really matters to me.

In my maiden speech, I pledged to campaign for people to have greater control in their final days and to afford those with terminal diagnoses the right to end their lives in dignity. This is not an argument against palliative care—some wonderful Macmillan nurses made my nan's final months as comfortable as possible, and I absolutely agree with the many Members who have raised the issue today that we need to do more to support our palliative care sector—but good palliative care and a dignified end of life are not mutually exclusive.

Nor do I seek to control those who have strong religious beliefs. Those who believe that only God can take life have the complete freedom to wait for that moment. But that is their choice. *[Interruption.]* I am not taking any interventions. Many have legitimate concerns about safeguarding. Of course, the most vulnerable should not be coerced into making a decision. However, this Bill introduces specific offences for this. Indeed, combined with sign-off by two independent doctors, judicial oversight and a period of reflection, this means there would be robust mechanisms to protect the most vulnerable.

Neil O'Brien: Will my hon. Friend give way?

Mr Bedford: I am not giving way.

These details are vital, but so is our humanity. Being with my nan in the warmth of her home, as she was surrounded by her loving family after months of excruciating pain and no hope, I knew there and then that she should be able to choose her time to say goodbye to her family. Like so many others, she had had enough. An understanding and compassionate society should not stand in the way of her right to choose.

Members can see the profound impact this has had on me and my belief in the importance of end of life care and choice. It has enabled me to understand a crucial distinction at the heart of this emotive debate. This is not about shortening life; it is about shortening death.

I urge those Members who support the principle of this Bill, but who are concerned about the specifics of the safeguards, to support it on Second Reading. Further debate can be had in Committee, if hon. Members feel that changes are required. This Bill provides the choice to shorten death, which is a right that an empathetic and considerate society should afford its citizens.

1.36 pm

Dawn Butler (Brent East) (Lab): I thank my hon. Friend the Member for Spen Valley (Kim Leadbeater) for how this debate has been conducted.

Yesterday, we buried Tony Warr, a GMB officer and a really good friend. He was diagnosed with prostate cancer. He beat it once, but it took him in the end.

Earlier this week, the cancer community lost Nina Lopes. She had stage 4 triple-negative breast cancer and was given six months to live in 2018. Six months became six years, and she taught us how to dance through her @frodayss account.

As we have heard, it is not an exact science when someone is given a prognosis of six months to live. As a patron of Black Women Rising, a cancer charity that supports black and minoritised women through their cancer journey, someone who had been given six months to live recently told me, "I have had a good life, and I am ready to go." Six weeks later, they are now fighting to live. The thing is, if we had focused only on the fact that she was ready to go and wanted to die, it would have all been very different.

As we have heard today, there are parts of the law that need changing around coercion, and around doctors being able to help people with their end of life treatment. However, I believe those safeguards and discussions can be separated from assisted dying and assisted suicide. I do not see why we need to have a combined discussion.

[Dawn Butler]

Everybody has the right to die with dignity and compassion. Whether or not this Bill progresses today, I hope those conversations will continue. After all, we are legislators, and we have the ability to do that. Eighty per cent of my constituents are against this legislation, and I will be voting against it.

1.37 pm

Christine Jardine (Edinburgh West) (LD): It is an honour to follow the hon. Member for Brent East (Dawn Butler). I also pay tribute to the hon. Member for Spen Valley (Kim Leadbeater). The spirit in which this debate has been conducted today is a tribute to her leadership on this issue.

This debate has been harrowing for all of us. However, to us falls the responsibility and the privilege of making this decision on behalf of those who go through experiences so harrowing that I do not think any of us can imagine them, even though we have heard their tales—I know that I cannot.

Until recently, I put it to the back of my mind that I have actually been in the situation of waiting to find out whether I would have a terminal diagnosis. I was lucky, as it went the other way. I do not know what I would have wanted but, as I waited, I thought about all the things I wanted to do and might be denied. People with a terminal diagnosis think about what they planned to do with their life, such as seeing their children and grandchildren grow and marry.

When we came here today, we were all aware of that, and we thought seriously about the implications and the need for palliative care, but it is not our job to say that we should not do this because palliative care needs to be improved and because the NHS cannot cope. Our job is to say that we need to improve palliative care so that the NHS can cope, and so that we can do this.

On the safeguards that are needed and included in the Bill, I believe they are there. For those with religious beliefs that mean they cannot countenance the Bill, I understand and respect their concerns, but I would not be standing here if I was not convinced that in this Bill we have the best opportunity to provide a choice safeguarded by medical and legal professionals and protected from that slippery slope. It happened in Canada because they did not have “terminal diagnosis” in the definition of the Bill from the beginning, but we do. If we vote the Bill through, it will go on to have the further and tougher levels of scrutiny that every piece of legislation in this place and the other place must go through. I respect everyone’s concerns and beliefs, but I also ask them, and all hon. Members, to respect those who have already been denied so much in their lives—those things I said they might want that they might be denied.

We have a choice today: we can lead a national conversation that examines the issue before all of us, dissect the Bill line by line and check its effectiveness, or we can vote to close it down today, and then the country and the families who are suffering will be denied the light they want to see thrown on the issue and the voice they want their loved ones or perhaps themselves to have.

Many of us have watched loved ones die difficult deaths, and we have over the past few weeks, months and years in politics heard harrowing tales and spoken to families who have had no choice but to watch their loved ones pass in the most harrowing of circumstances, or make an expensive—for many, prohibitively expensive—trip to Dignitas alone. I cannot help about those things they have been denied by the cruellest of fates, but surely we cannot deny them choice at end of life.

1.41 pm

Catherine Fookes (Monmouthshire) (Lab): I thank my hon. Friend the Member for Spen Valley (Kim Leadbeater) for the incredibly sensitive and thoughtful way she is conducting the passage of the Bill, consulting widely with terminally ill people and their families, medical staff, lawyers, faith leaders and those on both sides of the debate.

I have two very personal stories about why I support a change in the law. Last year, my dad’s health took a turn very much for the worse. He had sepsis, kidney failure and heart disease and had lived with Addison’s disease for almost 50 years. He was given the dreaded news that he only had a few months left to live. I would not have wished his last few weeks upon anyone. He was in agony and suffering—his breathing was difficult and he was in such pain. I struggled to see him suffer so much, but the nurses, doctors, carers and my incredible step-mum were all without fault and, thankfully, his palliative care was excellent. He was able to die at home with me, my sister and my step-mum by his side. Seeing him suffer so terribly convinced me that we need a change in the law so that people who are terminally ill have a choice.

My second story is from Australia where my brother lives. My wonderful sister-in-law Kelly sadly died of liver cancer that developed into bone cancer. She had a fractured left arm, pelvis and sacrum, and had cancer in her spine. At 54, Kelly was far too young to die. Her cancer was particularly painful and unforgiving. As she lived in Victoria, she was able to register for assisted dying. For her, it was incredibly comforting to know that if, and only if, she needed to, she could stop the suffering. She did not need it in the end, but she did have the option. In her darkest days—her fearful days—that brought her and my brother incredible peace of mind.

I heard similar stories of suffering in the hundreds of emails sent to me by constituents over the course of the past few months. People want and deserve access to both the best palliative care and a choice if they are terminally ill. The protections and evidence underpinning the Bill are strong. I was there for my dad’s final week when he was in so much pain, and I was there right at the end holding his hand. What a privilege to be with him at the end and to see him through. In memory of my dad and of Kelly, I support the Bill and urge all those across the House to support it, too.

1.44 pm

Jim Allister (North Antrim) (TUV): This is not an easy subject, nor should it be, because this is a matter of the taking of human life—the taking of human life, sanctioned by the state.

Our nation, through many wonderful charities and through Government, reaches out compassionately to those who are threatening suicide. They are urged to use the services of the Samaritans and to get all the help they can. I cannot square the circle where the state would then move to itself sanction suicide—indeed, to facilitate and, in fact, to promote suicide. And to do that in respect of those who are intrinsically the most vulnerable in our society. Anyone who gets a diagnosis of terminal illness is, by reason of that, obviously vulnerable. Many, in consequence, suffer depression and other difficulties, so they are among the most vulnerable in our society. Being vulnerable, they are among those most liable to fall under the foul influence of coercion.

Coercion comes in many forms. Anyone who has listened to domestic abuse cases will know that it can be very insidious, invasive and persuasive, because the coercer has the constant ear of those they wish to coerce. Add into that mix the fact that that person might feel a burden. We have all heard old people say, "I am a burden on society. I am a burden on my family." Even when they are told, "No, caring for you is not a chore, but a privilege," they still think they are a burden. If in that background—that matrix—there is still the pernicious influence of coercion, then the thought that people reach a reasoned, considered, independent opinion is a fallacy.

It is those people that this House should be protecting above all, but this Bill does not protect people in that situation. Oh, we are told, "two doctors and a judge". The judge does not have to, but he might decide to hold Zoom call with the applicant, but he is not to know if sitting in the corner of the room, out of camera shot, is the coercer. Where is the protection in that?

I say to the House that this issue cuts to the very quick of our fundamental duty to be the protectors of the most vulnerable. There is no part of the state's function to be promoting or assisting the end of life for people who could be in that condition, and we will never know how many are in that condition, so I cannot and will not vote for the Bill.

1.48 pm

Ruth Jones (Newport West and Islwyn) (Lab): It is an honour and a privilege to speak in the debate and to follow so many hon. Members who have made such powerful contributions. I thank my hon. Friend the Member for Spen Valley (Kim Leadbeater)—no longer in her place—for all her work on the Bill; colleagues from across the House who have worked together so collegiately; my constituents who have written to me in their hundreds; and the experts who shared their views with us.

Everybody in the Chamber wants a good death, but at the moment palliative care across the UK is chronically underfunded, mostly paid for with money raised by charities and a postcode lottery. I pay tribute to all the hospices that are working around the clock and doing an amazing job on very stringent budgets, especially St David's Hospice and the Hospice of the Valleys, which do amazing work. However, we have to remember that although we are talking about people with very powerful stories—some of whom are here today—we legislate for all, and that means ensuring that our legislation is safe and future-proofed.

I have concerns about the Bill on issues such as presuming consent. My worry is that if the door is opened with this Bill, it will then be widened, as it has been in places such as the Netherlands, Belgium and Canada. These things will happen.

More than 65 private Member's Bills were passed in the last Parliament. Not one of them had more than one sitting in Committee, where the average length of debate was 35 minutes; and just over a quarter had any amendments made to them at all. My hon. Friend the hon. Member for Spen Valley has said that she is willing to extend it, which I welcome; I will be pressing her on that to ensure it is safe. If the House votes to carry the Bill forward—I will be voting against it—scrutiny will be crucial at all points of its passage.

We have talked about terminal illness today, but intractable pain is something that people live with every day. That is another issue. In my 30 years as a physiotherapist, I have seen good deaths and bad deaths. We all want to ensure that we get the best for our constituents, so we need to ensure that end of life care is sorted. This has been a good debate, because we have talked—I have certainly talked to my family. My lovely mum of 89, who is disabled, housebound and widowed, said, "It's all very well talking about assisted dying, but we need to talk about assisted living as well, because that is most important." Quality of life is crucial here.

We need to ensure that we are here to legislate for all, which is why I will vote against the Bill today. I am grateful for the opportunity to explain.

1.51 pm

Saqib Bhatti (Meriden and Solihull East) (Con): I acknowledge the importance of this debate and thank the hon. Member for Spen Valley (Kim Leadbeater) for bringing it forward. Although I will be voting against the Bill, I still think this is an important discussion to have, not least because many of my constituents believe that it is the right thing to do. Of course, there are also many who feel that it is not the right thing to do. We have shown the very best of what Parliament can do here today.

I came to my conclusion not because of some sort of zealotry or evangelism. I completely acknowledge that there are people who go through very difficult situations where they lose their normal faculties and are in immense pain. However, we need to be clear about what we are discussing today: we are talking about wholesale change to how the state deals with death. That is really important. The Bill would place people, society and the medical profession in a number of scenarios, and put at great risk some of our most vulnerable people. That is part of the reason I will vote against it today.

The slippery slope arguments are valid in terms of the risk the legislation produces. We are talking about medicalising death, placing an undue burden on our health professionals and legitimising a role for the state in the death process.

Neil O'Brien: Will my hon. Friend give way?

Saqib Bhatti: I will not give way at this moment.

I have yet to be convinced that the legislation has sufficient safeguards in place. On slippery slopes, take Canada as an example: there, someone does not even have to have a terminal or fatal illness now; mental illness will be an acceptable reason for assisted suicide in 2027. Even though it did not start that way in Canada, that Pandora's box has clearly been opened, and we risk embarking on that route today. The hon.

[Saqib Bhatti]

Member for Spen Valley has said that there is almost a guarantee that this situation will not change, but she cannot guarantee that future Parliaments will not change the goalposts on this matter. The slippery slope argument is about exactly that: when we embark on this journey, that is where we may end up, as the goalposts start to move.

I am conscious of time, so I will end my comments shortly. We have had lots of conversation about the private Members' Bills process, and the hon. Lady cannot guarantee that there will be sufficient scrutiny and safeguards. We have not had enough impact assessments or public consultation, and there has been very limited time to look at this piece of legislation. We are at serious risk of passing something that will do immense harm. I worry that in the future we will look back at this, after there has been abuse or coercion of some of the most vulnerable people, and we will come back to the House to discuss the damage that we have caused today.

Several hon. Members *rose*—

Kim Leadbeater: On a point of order, Mr Speaker. I seek your guidance on correcting the record. I said in my speech that I have consulted with the highest levels of the judiciary and the medical profession. [*Official Report*, 29 November 2024; Vol. 757, c. 1019.] I have received correspondence from the Judicial Office and wish to clarify my earlier comments. Although I have spoken to lawyers and judges, I should not have implied that the serving judiciary have in some way indicated their agreement with the Bill; they have not. The serving judiciary have been very clear that they have made no public comments about the Bill one way or the other. I apologise if I implied anything to the contrary.

Mr Speaker: I thank the hon. Lady for correcting the record.

1.55 pm

Rosie Wrighting (Kettering) (Lab): I rise to support this incredibly important Bill. Like many hon. Members, I have been contacted by hundreds of constituents on both sides of the debate. I have been moved by their personal stories, which bring home the impact that this legislation could have on them and their families, and I want to put on record my thanks to everyone who has contacted me. I fundamentally believe in the right to choose at the end of life, and that is what the Bill is about: giving dying people a choice on how they die. Anyone who does not want an assisted death can choose not to have one, and anyone who wants the reassurance of an option has it.

My constituents' stories and the stories shared by hon. Members today have shown me that it is truly unacceptable to maintain the status quo. Without a change in the law, terminally ill people will continue to face the end of their lives with a very limited range of options. Some will travel abroad for help to die, but that is only an option for those with the financial means to do so. Choice at end of life should not be an option only for those who are financially stable or desperate. Death should be peaceful and pain-free, and the Bill gives us the opportunity to make that a reality. There is no doubt in my mind that the Bill, so carefully considered by my hon. Friend the Member for Spen Valley (Kim Leadbeater), would be an improvement for the lives and liberties of my constituents and those across the UK who are terminally ill. I urge Members to give it a Second Reading today.

I want to end with the words of one of my constituents, who wrote:

> "We have some amazing care givers in this country who provide the most compassionate care in the most difficult of circumstances & that gives great comfort. But I feel no-one should be forced to know how the book ends when they are only part way through it without having the choice of putting it down and choosing one with a better ending."

Mr Speaker: For the final Back-Bench speech, I call Vikki Slade.

1.57 pm

Vikki Slade (Mid Dorset and North Poole) (LD): We do not need to choose between palliative care and supporting those who want to make their deaths better. It is so fantastic to hear Members from every part of the Chamber with a shared commitment to funding more palliative care, and I hope that the Secretary of State and his team hear that and will go further, knowing that they have our support in investing more. But until they do, we cannot condemn those who are at the end of life to terror, loneliness and being forced into horrible circumstances.

I have been concerned by some of the comments in the debate, so I re-read the Bill as I sat here. It has been suggested that mental health conditions would be included, but they would not—under clause 2(3). It was also suggested that people might not be offered surgery or other treatment, but they must, under clause 4(4). It is also worth noting the suggestion that a person being coerced could be protected by disclosing to the very family that might be coercing them. The provision for a witness in clause 5(2)(c)(ii) and the period of reflection would allow the independent person to be present at the appropriate time.

I have already shared publicly my own family's death journeys—and I wear them on my jacket—but today is not about them. Today is about all those people who need this Bill. Last night I read the book "Die Smiling", about Nigel's journey to Dignitas. It ends with his final journey and a Facebook post, prepared before he made that agonising 20-hour journey to Switzerland with his wife and children. It moved me to tears. However, most people cannot afford that option. Most do not want to put their families at risk of prosecution; they want death on their own terms.

Gary lives in my constituency, and he asked me to tell the House his story of dying with liver cancer. He knows that the end stages will be brutal, and he wants to decide when enough is enough. He me:

> "Death does not worry me at all. Dying a slow death with my dignity stripped away terrifies me. So when my time is right I will kill myself—alone and afraid. My sick dog will not have to die alone and afraid, but I am forced to do so. I want to die on my terms. How can this be right?"

Tracie, who was a palliative care nurse, told me:

> "I've witnessed many end of life patients and I cannot say hand on heart that many of those patients had a peaceful death. I left palliative nursing as the emotional trauma became too

much. There are neither the range of medication or symptom relief treatments available for many of the harrowing things people are forced to go through in their last days and weeks of their life."

This Bill is about compassion and humanity, and we must listen to the voices of dying people.

Mr Speaker: I call the shadow Minister.

2.1 pm

Dr Kieran Mullan (Bexhill and Battle) (Con): Today the focus is rightly on Back Benchers, so I will limit my remarks and—mindful of your advice on time, Mr Speaker—I will not be taking any interventions.

It is not for me to make the case for His Majesty's Opposition, because we have not taken a collective view, and, like many other Members, I have struggled greatly with this decision. I do not believe there is a perfect choice to be made today, just different versions of imperfection, and my time working as a doctor in A&E has made me sympathetic to both sides of the argument. I have seen the pain in the eyes of relatives who want to ease the suffering of their dying loved ones, but I have also held the hand of frail elderly people, forgotten by their families, feeling themselves to be nothing but a burden. When we reduce it to its core, we are facing a difficult dilemma.

Access to assisted dying could reduce suffering for the terminally ill. That is a choice that some people would like to have, and some people would make that choice without any undue pressure. If we vote against this Bill today, they will not have that choice. I caution against avoiding facing up to this hard moral reality by arguing that whatever people may fear about dying can always be managed by modern medicine. For all that it can achieve, modern medicine cannot achieve everything. We have heard examples today of the worst illnesses that do more than cause pain. The hon. Member for Bury St Edmunds and Stowmarket (Peter Prinsley) and my hon. Friend the. Member for Hinckley and Bosworth (Dr Evans) described dying from a catastrophic bleed that takes a person's life in a panicked final moment.

Of course, the treatments we may use to help people with pain often rob them of what they may sincerely feel to be their own independence and dignity. Some people may not want to spend their final days in a drug-induced state of semi-consciousness to manage their pain. Those minded to vote against the Bill should give that the greatest possible consideration. I do not think that the Bill's opponents can deny it, any more than its proponents can deny that if this law is passed, it will represent the crossing of a significant legal, societal and moral Rubicon. Every other expectation that we have of the state is for it to help to extend and protect life, but we will instead be asking the state to procure the medicines, provide the staff, and sign off through the courts a process that is designed to lead—and will lead—to someone's death.

A deep respect for the sanctity of life is not the preserve only of religious thinkers. Opponents of the Bill place great weight on that consideration. They argue that once we accept that the state and its citizens can play a proactive role in causing death, the debate will shift from whether it should do that at all to how and when it should. It may be that we pass this legislation and no other in future, but those who have the utmost concern about even the possibility of an expanded Bill may vote against this one as the surest way for them personally to prevent that from happening.

The Mother of the House, the right hon. Member for Hackney North and Stoke Newington (Ms Abbott), argued that coercion is not limited to the selfishly motivated relative directly pressuring a vulnerable person. It can be as simple as knowing that people in the same position as oneself could and did choose to die. Some Members worry that people will then ask themselves not just "Do I want to die?", but "Should I want to die?"

So where does this leave us? All of us can make a sensible and reasonable case for our positions, and even point to care and compassion, as we see it, in support of our view. Taking all this together, I think it means that one thing more than anything else should be our guiding principle today: we should, above all else, vote with great humility, and with respect for each and every vote cast in whichever direction. I want to direct that sentiment to the country at large. There are passionate campaigners on both sides of the debate, with their own perspectives, who fear greatly the outcome today if it turns out not to be the one that they want. I say to them that as well as being MPs, those voting today are also sons, daughters, brothers, sisters, parents and grandparents. Each Member will have in mind what they would want for their families and themselves.

Our final decisions will come at the end of a great deal of thought and careful consideration. As the hon. Member for Vauxhall and Camberwell Green (Florence Eshalomi) said, if people listened closely enough today they will have heard us all speaking with one voice—the voice of passion, for those people and causes that we are trying to aid with our vote, even if those people and causes are different. That passion represents this House at its very best. That should not be forgotten. I hope that it is something on which we can all agree.

2.5 pm

The Parliamentary Under-Secretary of State for Justice (Alex Davies-Jones): This Second Reading debate on the Bill sponsored by my hon. Friend the Member for Spen Valley (Kim Leadbeater) provides the House and the country with an opportunity to discuss this complex and sensitive issue. I make it clear that I stand at the Dispatch Box today not as the MP for Pontypridd representing the views of my constituents, although I thank each and every one of them who took the time to contact me with their considered opinions. I stand here today as the Government Minister responsible for the criminal law on this issue in England and Wales, contained in the Suicide Act 1961.

As the Government remain neutral on this topic of conscience, and out of respect for my ministerial colleagues who are not able to outline their views in today's debate, I will not be sharing my personal opinions on this matter. I will, however, be taking part in the vote. With all that in mind, I will keep my response brief and not take any interventions. The Government are of the view that any change to the law in this area is an issue of conscience for individual parliamentarians. It is rightly, in our view, a matter for Parliament rather than the Government to decide. Accordingly, the Government Benches will have a free vote should the views of the House be tested today.

[Alex Davies-Jones]

If the will of Parliament is that the law in this area should change, the Government will of course respect their duty to the statute book and ensure that any Bill is effective and its provisions can be enforced. I thank my hon. Friend the Member for Spen Valley for bringing this important national conversation to the fore and for conducting her campaign with respect and integrity. I pay tribute to the campaigners on both sides of the debate, including Dame Esther Rantzen, Liz Carr, Nathaniel Dye and Baroness Grey-Thompson. They have all used their voices to advocate for what they believe and have contributed significantly to the important national conversation around death.

Regardless of views, the one thing we have in common is that we will all experience death at some point. Death is a topic that we do not tend to talk about very much, but these discussions have undoubtedly enabled families up and down the country to talk openly about their wishes and how they feel about their own death. That powerful honesty is a tribute to how Members of this House and campaigners have conducted themselves throughout, and I thank them for informing today's debate.

Kit Malthouse *claimed to move the closure (Standing Order No. 36).*

Question agreed to.

Question put accordingly, That the Bill be now read a Second time.

The House divided: Ayes 330, Noes 275.

Division No. 51] [2.8 pm

AYES

Akehurst, Luke
Aldridge, Dan
Alexander, Heidi
Al-Hassan, Sadik
Anderson, Callum
Anderson, Lee
Antoniazzi, Tonia
Aquarone, Steff
Athwal, Jas
Atkins, rh Victoria
Atkinson, Lewis
Babarinde, Josh
Bailey, Mr Calvin
Ballinger, Alex
Barker, Paula
Barron, Lee
Barros-Curtis, Mr Alex
Beales, Danny
Beavers, Lorraine
Bedford, Mr Peter
Bell, Torsten
Benn, rh Hilary
Bennett, Alison
Berry, Siân
Betts, Mr Clive
Bishop, Matt
Blake, Olivia
Blake, Rachel
Bloore, Chris
Bonavia, Kevin
Botterill, Jade
Brandreth, Aphra
Brash, Mr Jonathan
Brewer, Alex
Brickell, Phil
Brown-Fuller, Jess
Buckley, Julia
Burke, Maureen
Burton-Sampson, David
Cadbury, Ruth
Campbell, rh Sir Alan
Campbell, Irene
Campbell-Savours, Markus
Cane, Charlotte
Carling, Sam
Carmichael, rh Mr Alistair
Cartlidge, James
Chadwick, David
Chamberlain, Wendy
Chambers, Dr Danny
Champion, Sarah
Charters, Mr Luke
Chowns, Ellie
Coghlan, Chris
Collier, Jacob
Collinge, Lizzi
Collins, Victoria
Coombes, Sarah
Cooper, Andrew
Cooper, Dr Beccy
Cooper, Daisy
Cooper, rh Yvette
Costigan, Deirdre
Cox, Pam
Creasy, Ms Stella
Curtis, Chris
Daby, Janet
Dakin, Sir Nicholas
Dance, Adam
Darling, Steve
Darlington, Emily
Davies, Paul
Davies, Shaun
Davies-Jones, Alex
Davis, rh David
Dean, Bobby
Dean, Josh
Dearden, Kate
Denyer, Carla
Dickson, Jim
Dillon, Mr Lee
Dinenage, Dame Caroline
Dixon, Samantha
Dollimore, Helena
Dowd, Peter
Dowden, rh Sir Oliver
Downie, Graeme
Duncan-Jordan, Neil
Dyke, Sarah
Eagle, Dame Angela
Eagle, rh Maria
Eastwood, Colum
Eccles, Cat
Edwards, Lauren
Edwards, Sarah
Efford, Clive
Egan, Damien
Elmore, Chris
Entwistle, Kirith
Esterson, Bill
Evans, Dr Luke
Fahnbulleh, Miatta
Falconer, Hamish
Farnsworth, Linsey
Ferguson, Mark
Fleet, Natalie
Foody, Emma
Fookes, Catherine
Foord, Richard
Forster, Mr Will
Foster, Mr Paul
Fox, Sir Ashley
Franklin, Zöe
Freeman, George
Garnier, Mark
Gelderd, Anna
Gemmell, Alan
George, Andrew
German, Gill
Gibson, Sarah
Gilbert, Tracy
Gilmour, Rachel
Gittins, Becky
Glover, Olly
Goldman, Marie
Gordon, Tom
Gosling, Jodie
Gould, Georgia
Green, Sarah
Greenwood, Lilian
Hack, Amanda
Haigh, rh Louise
Hall, Sarah
Hamilton, Fabian
Hardy, Emma
Hatton, Lloyd
Hayes, Tom
Hazelgrove, Claire
Healey, rh John
Heylings, Pippa
Hinchliff, Chris
Hinder, Jonathan
Hobhouse, Wera
Hodgson, Mrs Sharon
Hollinrake, Kevin
Hopkins, Rachel
Hughes, Claire
Hume, Alison
Hunt, rh Jeremy
Ingham, Leigh
Irons, Natasha
Jardine, Christine
Jarvis, Dan
Jarvis, Liz
Jermy, Terry
Johnson, rh Dame Diana
Johnson, Kim
Jones, Clive
Jones, Gerald
Jones, Louise
Jones, Sarah
Juss, Warinder
Kane, Chris
Kearns, Alicia
Kendall, rh Liz
Kinnock, Stephen
Kirkham, Jayne
Kitchen, Gen
Kumar, Sonia
Kyle, rh Peter
Kyrke-Smith, Laura
Lake, Ben
Law, Noah
Leadbeater, Kim
Lewin, Andrew
Lewis, Clive
Lightwood, Simon
Lowe, Rupert
MacAlister, Josh
MacCleary, James
Macdonald, Alice
MacNae, Andy
Maguire, Ben
Maguire, Helen
Malthouse, rh Kit
Martin, Amanda
Martin, Mike
Mather, Keir
Mathew, Brian
Mayer, Alex
Maynard, Charlie
McCarthy, Kerry
McDonnell, rh John
McFadden, rh Pat
McGovern, Alison
McKenna, Kevin
McMorrin, Anna
McNeill, Kirsty *(Proxy vote cast by Chris Elmore)*
Medi, Llinos
Mierlo, Freddie van
Miliband, rh Ed
Milne, John
Mitchell, rh Mr Andrew
Moon, Perran
Moran, Layla
Morden, Jessica
Morello, Edward

Morgan, Helen
Morgan, Stephen
Morris, Joe
Munt, Tessa
Murphy, Luke
Murray, Chris
Murray, James
Murray, Susan
Myer, Luke
Naismith, Connor
Nandy, rh Lisa
Narayan, Kanishka
Nash, Pamela
Niblett, Samantha
Nichols, Charlotte
Norris, Alex
Norris, Dan
Onn, Melanie
Opher, Dr Simon
Osborne, Kate
Osborne, Tristan
Payne, Michael
Pearce, Jon
Pennycook, Matthew
Perkins, Mr Toby
Perteghella, Manuela
Phillips, Jess
Philp, rh Chris
Pinkerton, Dr Al
Pitcher, Lee
Platt, Jo
Pollard, Luke
Powell, Joe
Powell, rh Lucy
Poynton, Gregor
Prinsley, Peter
Race, Steve
Ramsay, Adrian
Rand, Mr Connor
Ranger, Andrew
Reed, rh Steve
Reeves, rh Rachel
Reid, Joani
Reynolds, Emma
Reynolds, Mr Joshua
Richards, Jake
Riddell-Carpenter, Jenny
Rigby, Lucy
Robertson, Dave
Roca, Tim
Roome, Ian
Russell, Mrs Sarah
Rutland, Tom
Ryan, Oliver
Sabine, Anna
Sackman, Sarah
Sandher, Dr Jeevun
Savage, Dr Roz
Saville Roberts, rh Liz
Sewards, Mr Mark
Shanker, Baggy
Shastri-Hurst, Dr Neil
Siddiq, Tulip
Simons, Josh
Slade, Vikki
Slaughter, Andy
Slinger, John
Smart, Lisa
Smith, Jeff
Smyth, Karin
Snell, Gareth
Snowden, Mr Andrew
Sollom, Ian
Stainbank, Euan
Starmer, rh Keir
Stevens, rh Jo
Stewart, Elaine
Stone, Will
Strathern, Alistair
Stride, rh Mel
Sunak, rh Rishi
Swallow, Peter
Tami, rh Mark
Tapp, Mike
Taylor, David
Taylor, Luke
Taylor, Rachel
Thomas, Cameron
Thomas, Fred
Thompson, Adam
Thornberry, rh Emily
Tice, Richard
Tidball, Dr Marie
Trott, rh Laura
Tufnell, Henry
Turley, Anna
Turmaine, Matt
Turner, Karl
Uppal, Harpreet
Vaughan, Tony
Vince, Chris
Voaden, Caroline
Wakeford, Christian
Ward, Chris
Webb, Chris
Welsh, Michelle
West, Catherine
Western, Andrew
Western, Matt
Wheeler, Michael
Whitby, John
White, Jo
White, Katie
Whittome, Nadia
Wild, James
Wilkinson, Max
Witherden, Steve
Wrighting, Rosie
Wrigley, Martin
Yang, Yuan
Yemm, Steve
Young, Claire
Zeichner, Daniel

Tellers for the Ayes:
Bambos Charalambous and Sarah Owen

NOES

Abbott, rh Ms Diane *(Proxy vote cast by Bell Ribeiro-Addy)*
Abbott, Jack
Adam, Shockat
Ahmed, Dr Zubir
Alaba, Mr Bayo
Ali, Rushanara
Ali, Tahir
Allin-Khan, Dr Rosena
Allister, Jim
Amesbury, Mike *(Proxy vote cast by Chris Elmore)*
Amos, Gideon
Anderson, Fleur
Anderson, Stuart
Andrew, rh Stuart
Argar, rh Edward
Arthur, Dr Scott
Asato, Jess
Asser, James
Atkinson, Catherine
Bacon, Gareth
Badenoch, rh Mrs Kemi
Bailey, Olivia
Baines, David
Baker, Alex
Baker, Richard
Bance, Antonia
Barclay, rh Steve
Baxter, Johanna
Begum, Apsana
Bhatti, Saqib
Billington, Ms Polly
Blackman, Bob
Blundell, Mrs Elsie *(Proxy vote cast by Chris Elmore)*
Bool, Sarah
Bowie, Andrew
Brackenridge, Mrs Sureena
Bradley, rh Dame Karen
Braverman, rh Suella
Burghart, Alex
Burgon, Richard
Butler, Dawn
Byrne, Ian
Byrne, rh Liam
Caliskan, Nesil
Campbell, Mr Gregory
Campbell, Juliet
Chope, Sir Christopher
Clark, Feryal
Cleverly, rh Mr James
Cocking, Lewis
Coleman, Ben
Collins, Tom
Conlon, Liam
Cooper, John
Corbyn, rh Jeremy
Costa, Alberto
Coutinho, rh Claire
Cox, rh Sir Geoffrey
Coyle, Neil
Craft, Jen
Creagh, Mary
Crichton, Torcuil
Cross, Harriet
Dalton, Ashley
Davey, rh Ed
Davies, Ann
Davies, Gareth
Davies, Jonathan
Davies, Mims
De Cordova, Marsha
Dhesi, Mr Tanmanjeet Singh
Dixon, Anna
Dodds, rh Anneliese
Doughty, Stephen
Duffield, Rosie
Duncan Smith, rh Sir Iain
Easton, Alex
Eastwood, Sorcha
Ellis, Maya
Evans, Chris
Farage, Nigel
Farron, Tim
Ferguson, Patricia
Fortune, Peter
Foxcroft, Vicky
Foy, Mary Kelly
Francis, Daniel
Francois, rh Mr Mark
French, Mr Louie
Frith, Mr James
Fuller, Richard
Furniss, Gill
Gale, rh Sir Roger
Gardiner, Barry
Gardner, Dr Allison
Gill, Preet Kaur
Glen, rh John
Glindon, Mary
Goldsborough, Ben
Grady, John
Grant, Helen
Griffith, Andrew
Griffith, Dame Nia
Griffiths, Alison
Hamilton, Paulette
Harding, Monica
Hardy, Emma
Harris, Rebecca
Hayes, Helen
Hayes, rh Sir John
Hendrick, Sir Mark
Hillier, Dame Meg
Hinds, rh Damian
Hoare, Simon
Holden, rh Mr Richard
Holmes, Paul
Huddleston, Nigel
Hudson, Dr Neil
Huq, Dr Rupa
Hurley, Patrick
Hussain, Mr Adnan
Hussain, Imran
Jameson, Sally
Jenkin, Sir Bernard
Jenrick, rh Robert
Jogee, Adam
Johnson, Dr Caroline
Jones, rh Darren
Jones, Lillian
Jones, Ruth
Jopp, Lincoln
Josan, Gurinder Singh
Joseph, Sojan
Kane, Mike
Kaur, Satvir
Khan, Ayoub
Khan, Naushabah
Kohler, Mr Paul
Kruger, Danny
Kumaran, Uma
Lam, Katie
Lammy, rh Mr David
Lamont, John
Lavery, Ian
Leigh, rh Sir Edward
Leishman, Brian
Lewell-Buck, Mrs Emma
Lewis, rh Sir Julian
Lockhart, Carla
Long Bailey, Rebecca
Lopez, Julia

MacDonald, Mr Angus
Madders, Justin
Mahmood, rh Shabana
Mak, Alan
Malhotra, Seema
Maskell, Rachael
Mayhew, Jerome
McAllister, Douglas
McCluskey, Martin
McDonagh, Dame Siobhain
McDonald, Andy
McDonald, Chris
McDougall, Blair
McEvoy, Lola
McIntyre, Alex
McKee, Gordon
McKinnell, Catherine
McMahon, Jim
McMurdock, James
McNally, Frank
McVey, rh Esther
Midgley, Anneliese
Miller, Calum
Minns, Ms Julie
Mohamed, Abtisam
Mohamed, Iqbal
Mohindra, Mr Gagan
Moore, Robbie
Morris, Grahame
Morrison, Mr Tom
Morrissey, Joy
Morton, rh Wendy
Mullan, Dr Kieran
Mullane, Margaret
Mundell, rh David
Murray, Katrina
Murrison, rh Dr Andrew
Naish, James
Newbury, Josh
Norman, rh Jesse
Obese-Jecty, Ben
O'Brien, Neil
Olney, Sarah
Onwurah, Chi
Oppong-Asare, Ms Abena
Osamor, Kate
Owatemi, Taiwo
Paffey, Darren
Pakes, Andrew
Patel, rh Priti
Patrick, Matthew
Paul, Rebecca
Peacock, Stephanie
Phillipson, rh Bridget
Pinto-Duschinsky, David
Pritchard, rh Mark
Quigley, Mr Richard
Qureshi, Yasmin
Raja, Shivani
Rankin, Jack
Rayner, rh Angela
Reader, Mike
Reed, David
Reynolds, rh Jonathan
Rhodes, Martin
Ribeiro-Addy, Bell
Rimmer, Ms Marie
Robertson, Joe
Robinson, rh Gavin
Rodda, Matt
Rosindell, Andrew
Rushworth, Sam
Scrogham, Michelle
Shah, Naz
Shanks, Michael
Shannon, Jim
Shelbrooke, rh Sir Alec
Simmonds, David
Smith, David
Smith, Greg
Smith, rh Sir Julian
Smith, Rebecca
Smith, Sarah
Spencer, Dr Ben
Spencer, Patrick
Stafford, Gregory
Stephenson, Blake
Stevenson, Kenneth
Stone, Jamie
Streeting, rh Wes
Strickland, Alan
Stringer, Graham
Stuart, rh Graham
Sullivan, Kirsteen
Sullivan, Dr Lauren
Sultana, Zarah
Swann, Robin
Swayne, rh Sir Desmond
Taylor, Alison
Thomas, Bradley
Thomas-Symonds, rh Nick
Timms, rh Sir Stephen
Timothy, Nick
Tomlinson, Dan
Trickett, Jon
Tugendhat, rh Tom
Turner, Laurence
Twigg, Derek
Twist, Liz
Vaz, rh Valerie
Vickers, Martin
Vickers, Matt
Walker, Imogen
Ward, Melanie
Waugh, Paul
Whately, Helen
Whittingdale, rh Sir John
Williams, David
Williamson, rh Sir Gavin
Wilson, Munira
Wilson, rh Sammy
Woodcock, Sean
Wright, rh Sir Jeremy
Yasin, Mohammad

Tellers for the Noes:
Dame Harriett Baldwin and
Florence Eshalomi

Question accordingly agreed to.

Bill read a Second time; to stand committed to a Public Bill Committee (Standing Order No. 63).

TERMINALLY ILL ADULTS (END OF LIFE) BILL: POWER OF PUBLIC BILL COMMITTEE TO SEND FOR PERSONS, PAPERS AND RECORDS

Ordered,

That the Public Bill Committee to which the Terminally Ill Adults (End of Life) Bill stands committed shall have the power to send for persons, papers and records.—*(Kim Leadbeater.)*

Mr Speaker: Under Standing Order No. 63(2) only one motion relating to the committal of the Bill may be moved, and that has been done.

Animal Welfare (Import of Dogs, Cats and Ferrets) Bill

Second Reading

2.25 pm

Dr Danny Chambers (Winchester) (LD): I beg to move, That the Bill be now read a Second time.

As we know, tens of thousands of puppies are illegally smuggled into the UK every year; it is a huge animal welfare problem. This Bill will help to close the issue of having mutilations in dogs. As a veterinary surgeon, I see many dogs with cropped ears and docked tails—acts that are illegal to perform in the UK. People are performing those acts in the UK then claiming that the puppies have been brought in from abroad. If we ban puppies coming in from abroad with those mutilations, it will be of huge benefit to animal welfare.

The Bill will also protect public health, because we know that the tens of thousands of dogs being brought in are not being tested for diseases such as rabies, which can affect people. This is also about serious organised crime: preventing tens of thousands of puppies being brought into the UK will help us to tackle the criminal gangs doing those acts.

In the interests of time, I will finish by saying that I am pleased to have cross-party support on this issue as well as the support of the entire veterinary profession. I thank the Dogs Trust, the Royal Society for the Prevention of Cruelty to Animals and the British Veterinary Association for all the work they did to help to make this happen.

Mr Speaker: I call the shadow Minister.

2.26 pm

Dr Neil Hudson (Epping Forest) (Con): Animal welfare unites us in humanity. As a veterinary surgeon, a Member of Parliament and the shadow Environment, Food and Rural Affairs Minister, I can proudly say that His Majesty's loyal Opposition strongly support this Bill in the interests of animal health and welfare.

2.27 pm

The Parliamentary Under-Secretary of State for Environment, Food and Rural Affairs (Mary Creagh): I congratulate the hon. Member for Winchester (Dr Chambers) and thank him for bringing forward this important Bill.

This Government take the issue of pet smuggling seriously. Earlier this year, we made a manifesto commitment to end puppy smuggling, and that is exactly what we will do. I am delighted to announce that the Government will be fully supporting the passage of the Animal Welfare (Import of Dogs, Cats and Ferrets) Bill through Parliament. We stand ready to work with the hon. Gentleman to clamp down on deceitful pet sellers who prioritise profit over welfare.

This Bill will crack down on pet smuggling by closing loopholes in the current pet travel rules. At present, illegal importers of dogs, cats and ferrets often exploit loopholes to bring in animals under the guise of genuine owners travelling with their pets. The Bill will close those loopholes by reducing the number of dogs, cats and ferrets that are permitted to be brought into Great Britain by a person under the pet travel rules. The limit will be reduced from five pets per person to five pets per vehicle, and three pets per foot or air passenger.

The Bill will also provide us with powers to crack down on low-welfare imports of pets. We will first use those powers to restrict the movement of heavily pregnant and mutilated dogs and cats into Great Britain. At the same time, we will raise the minimum age at which puppies and kittens can be brought into Great Britain, which will be set at six months. We will also ensure that the non-commercial movement of a pet into Great Britain must be linked to the movement of its owner. To move under the pet travel rules going forward, the pet and owner will have to travel within five days of each other.

In the interests of time, I again thank the hon. Member for Winchester for taking forward this important Bill and look forward to working together to progress it through the House.

Mr Speaker: Does the hon. Member for Winchester (Dr Chambers) wish to come back in?

Dr Chambers *indicated dissent.*

Mr Speaker: Good.

Question put and agreed to.

[Applause.]

Mr Speaker: How dare Members clap? I had enough with Roger!

Business without Debate

PALESTINE STATEHOOD (RECOGNITION) (NO. 2) BILL

Motion made, That the Bill be now read a Second time.

2.30 pm

The Speaker interrupted the business (Standing Order No. 11(2)).

Bill to be read a Second time on Friday 24 January 2025.

SPECIAL ENVOY FOR FREEDOM OF RELIGION OR BELIEF BILL

Motion made, That the Bill be now read a Second time.

Hon. Members: Object.

Bill to be read a Second time on Friday 28 March 2025.

EMPLOYMENT RIGHTS (SPECIAL CONSTABLES) BILL

Motion made, That the Bill be now read a Second time.

Hon. Members: Object.

Bill to be read a Second time on Friday 11 July 2025.

HEALTH AND SAFETY AT WORK ETC. ACT 1974 (AMENDMENT) BILL

Motion made, That the Bill be now read a Second time.

Hon. Members: Object.

Bill to be read a Second time on Friday 7 March 2025.

COVID-19 VACCINE DAMAGE BILL

Motion made, That the Bill be now read a Second time.

Hon. Members: Object.

Bill to be read a Second time on Friday 6 December.

DOGS (PROTECTION OF LIVESTOCK) (AMENDMENT) BILL

Bill read a Second time; to stand committed to a Public Bill Committee (Standing Order No. 63).

FOOTBALL (GENDER INEQUALITY) BILL

Motion made, That the Bill be now read a Second time.

Hon. Members: Object.

Bill to be read a Second time on Friday 16 May 2025.

CHILDREN'S HOSPICES (FUNDING) BILL

Motion made, That the Bill be now read a Second time.

Hon. Members: Object.

Bill to be read a Second time on Friday 24 January 2025.

PETITIONS

National bus fare cap

2.32 pm

Zarah Sultana (Coventry South) (Ind): I rise to present a petition on behalf of residents of the United Kingdom regarding the Government's decision to increase the bus fare cap by 50%. More than 105,000 people have signed a related change.org petition. The £2 fare cap introduced in January 2020 has been a lifeline for people, providing access to work, medical appointments and family connections during a period of mounting financial strain. Despite the crisis being far from over, the Government plan to raise the cap to £3 in January 2025, adding hundreds to annual commuter costs and risking isolation of vulnerable individuals.

The petitioners therefore request that the House of Commons urge the Government to reconsider the cap increase, and call for sufficient support to ensure that affordable public transport remains accessible and sustainable through 2025 and beyond.

[Zarah Sultana]

Following is the full text of the petition:

[The petition of residents of the constituency of Coventry South,

Declares that when the £2 bus fare cap was introduced in January 2020, it became a crucial lifeline for people across the country who rely on buses to get to work, attend medical appointments and visit family; further that this cap was introduced specifically to address the cost-of-living crisis, ensuring that bus travel remained affordable and accessible as households felt financial pressures intensify; further that despite the cost-of-living crisis being far from over, the government now plans to raise the fare cap to £3 from January 2025; further that a £1 increase could add hundreds of pounds to annual costs for daily commuters and may isolate others entirely from essential services and community support; and notes the positive impact of the £2 fare cap on people, especially for those in rural areas, where public transport options are more limited.

The petitioners therefore request that the House of Commons urge the Government to reconsider changes to the £2 bus fare cap, and to provide adequate support through 2025 to ensure that public transport is made easier, cheaper and more accessible.

And the petitioners remain, etc.]

[P003021]

Pimping websites and paying for sex

Jess Asato (Lowestoft) (Lab): I rise on the fifth day of the UN's 16 days of activism against gender-based violence, to present a petition on behalf of my Lowestoft constituents on commercial sexual exploitation. Pimping websites facilitate the trafficking and exploitation of women, yet remain readily accessible. These companies make millions of pounds out of extremely vulnerable women and are a core part of the business model of sex trafficking in the UK. The petitioners therefore request

"that the House of Commons urges the Government to outlaw pimping websites and paying for sex, and provide support, not sanctions, to victims of sexual exploitation."

Following is the full text of the petition:

[The petition of residents of the constituency of Lowestoft,

Declares that demand from the minority of men who pay for sex is driving the prostitution and sex trafficking trade, and this sexual exploitation is being facilitated by pimping websites that operate with impunity.

The petitioners therefore request that the House of Commons urges the Government to outlaw pimping websites and paying for sex, and provide support, not sanctions, to victims of sexual exploitation.

And the petitioners remain, etc.]

[P003024]

Jim Shannon (Strangford) (DUP): On a point of order, Mr Speaker. In the debate on the assisted dying Bill, the hon. Member for Spen Valley (Kim Leadbeater) assured the House that there would be cross-party support in relation to the make-up of the Bill Committee. Can you confirm, for *Hansard* and for my constituents back home, that the make-up of that Committee will represent the views of this House, ever mindful of the vote that took place? We are all aware that 334 voted for the Bill and 275 against; perhaps the Committee can accordingly reflect that representation in the House.

Mr Speaker: Unfortunately, that is not my responsibility; it is for the Member in charge of the Bill. I am sure that that point will have been heard. As I know the hon. Gentleman well, I do not think he will leave it there, and I am sure he will be in contact with the Member in charge to remind them.

Men's Violence against Women and Girls

Motion made, and Question proposed, That this House do now adjourn.—*(Taiwo Owatemi.)*

2.35 pm

Emily Darlington (Milton Keynes Central) (Lab): In January, Tia Simmonds was killed by her husband. Her body was hidden in a storage area in the loft of her home, lying face downwards, covered in clothing and bedding. In March, Wendy Francis was stabbed to death by her daughter's boyfriend, who also tried to kill her daughter. In April, Rachel McDaid was strangled to death with a bootlace by her estranged husband, who had broken into her house. In June, Rita Fleming was drowned in the bath after sustaining serious head injuries from her fiancé. In August, mother of three Courtney Mitchell was chased down the street and stabbed to death in broad daylight by her ex-boyfriend. Every three days in this country, a woman is murdered by a man. Any other murder or violent spree against a group in our society would be front-page news every single day.

Jim Shannon (Strangford) (DUP): I commend and congratulate the hon. Lady on securing this debate. I know that the Minister has a love of Northern Ireland, and in the last year six women have been murdered in Northern Ireland—I understand that all the cases are pending. Does that not illustrate that, no matter where we are in this great United Kingdom of Great Britain and Northern Ireland, the murder rate for women is absolutely abysmal?

Emily Darlington: I absolutely agree with the hon. Gentleman—*[Interruption.]* Or hon. Friend? I feel I know him now from so many interventions. *[Laughter.]* The fact that this is not front-page news, or top headline news, shows the discrimination and misogyny in the news coverage around the issue. We need to use our positions in the House to make sure it is heard about.

This year, it was confirmed that the most dangerous place for a woman to be anywhere in the world is in her own home. It is estimated that less than 24% of domestic abuse crime is reported to the police, yet the police receive domestic abuse-related calls every 30 seconds. Domestic abuse is devastating not just for the women in receipt of it but for the children who observe it. Domestic abuse comes in all forms—violent, emotional and financial. One in four women in England and Wales will experience domestic abuse in her lifetime.

Warinder Juss (Wolverhampton West) (Lab): In Wolverhampton last year, it was estimated that more than 6,000 women were subjected to domestic abuse. Will my hon. Friend commend the "Orange Wolverhampton" campaign, which runs from 25 November to 10 December every year? The campaign involves the Wolverhampton safeguarding team, the Safer Wolverhampton Partnership, and the City of Wolverhampton council working together to highlight the issue of men's violence against women, including domestic abuse and the violence against young women that is sadly so prevalent these days.

Emily Darlington: I know that Wolverhampton has many community campaigns to change the tide of violence against women and girls. I know that that has been happening in cities and towns across our country, but we need to be there to support those campaigns for them to have a true impact. I take this opportunity to thank an organisation in my own constituency, MK ACT, which has done enormous work, including running a refuge and perpetrator programmes to support not only those who have been victims of domestic abuse, but those who perpetrate it. Work such as that has been trying to stem the tide of abuse in our communities.

Sarah Smith (Hyndburn) (Lab): Do my hon. Friend and the Minister agree that we need to ensure the ongoing funding of the critical organisations in our communities that are supporting women and girls, such as the Emily Davison centre? It was the first centre for ending violence against women and girls to be established in the UK, in Accrington. Furthermore, will my hon. Friend pay tribute to the amazing work of one of the councillors in my constituency, Samara Barnes, who with Safer Rossendale is leading on a brilliant scheme in Haslingden to ensure that Christmas parties are safer this year, following on from the very important development in legislation tackling spiking of people's drinks?

Emily Darlington: It has been a long day for all of us, and I really appreciate that hon. Members have stayed so late on such an important day—

Mr Speaker: Don't worry about Jim!

Emily Darlington: Right—I am waiting for the next intervention. I agree with my hon. Friend the Member for Hyndburn (Sarah Smith) that councillors in their local communities and organisations such as that are making the difference and are the places that women are turning to because, unfortunately, the system is letting them down—not least around rape. Despite five out of six rapes not even being reported to the police, in the year ending July almost 70,000 women courageously reported their rape. Only 2.7% of those ever made it to charge and court, while for other crimes the rate is 7%. That means in this country it is easier to get away with rape than with robbery.

Sarah Dyke (Glastonbury and Somerton) (LD): I thank the hon. Member for securing this important debate. There are around 3,000 reports of violence against women and girls made in Somerset every month and at least one in 12 women experience violence against them each year. Many of those incidents go unreported. A constituent of mine was sadly regularly physically abused and gaslighted by her ex-partner, and she felt really disappointed and disillusioned with the police response. To me it is no wonder that so many women are not confident in reporting the abuse against them. So does the hon. Member agree with me that gaslighting is a serious problem in tackling violence against women and girls?

Emily Darlington: The hon. Member is absolutely right; we need to look at why women do not have confidence in reporting to police. Some of that will be because of the numbers that we have seen go through to prosecution, and because of their worries that it will get worse for them before it gets better and about the protection they may or may not receive.

[Emily Darlington]

However, I am really proud to be part of a Government that has declared violence against women and girls to be a national emergency. I am proud of the work we have already done, committing to halve it, with the introduction of the domestic abuse protection orders to give great greater protection to women, Raneem's law to transform how police handle domestic violence calls, workplace harassment laws, new protections for victims of stalking, and making spiking a specific criminal offence. No doubt that is down to the amazing women we have leading on this issue in Government, not least my hon. Friend the Minister, the Under-Secretary of State for Justice, my hon. Friend the Member for Pontypridd (Alex Davies-Jones), and my right hon. Friend the Home Secretary, and their absolute commitment and tireless work on this issue.

Mr Richard Holden (Basildon and Billericay) (Con): I congratulate the hon. Lady on securing this debate. What she is saying is absolutely right. Does she agree that changes in law made in this place can help lead to broader cultural change in society? We need to be at the forefront of these changes. Sometimes it can be quite difficult, but we must pick up that challenge, particularly when it comes to tackling violence against women and girls.

Emily Darlington: I thank the hon. Member for his intervention; I absolutely agree. When we see Members from across the House raising this issue in Northern Ireland questions, Westminster Hall and in the various debates we have, we know that it will have an impact on not only what the Government do but how men and women perceive this issue in our communities.

I want to talk about those perceptions, particularly the perceptions of young men. We often hear the platitude that for women it has always been this way, but is that actually true? A 2024 Crown Prosecution Service survey of 18 to 24-year-old men shows that it is not. Half of 18 to 24-year-olds think that it is not rape if the victim does not resist or fight back. Over half think that being in a relationship or marriage means that consent to sex can be assumed. Two thirds believe that if a person says online that they want to meet up and have sex, they are entitled to the sex when they meet, no matter whether the individual changes their mind. More than half think that if a man has been drinking or taking drugs, he is not responsible for the rapes he commits.

Will Stone (Swindon North) (Lab): Does the House agree that we need to do more to tackle toxic masculinity by people and influencers like Andrew Tate, because they are at the forefront of putting these ideas into the minds of young men?

Emily Darlington: I thank my hon. Friend for his intervention. I am just about to come on to that point.

The result of this survey showed that young men between 18 and 24 have a significantly poorer understanding of rape and consent than those over the age of 65. How has this happened? Young men are being radicalised in the same way as recognised terrorist groups radicalise people. There is this sense of entitlement, righteousness and belonging to community, but a community whose role models include Andrew Tate, who says that,

> "if you put yourself in a position to be raped, you must bear some responsibility",

and:

> "Losers love to talk about feelings."

Talking about women, he says "grip her by the neck" in a video viewed over 1.6 million times. Eight out of 10 boys between 16 and 17 know about, watch, read or listen to these videos, and almost half of them have a positive view of him.

Josh Fenton-Glynn (Calder Valley) (Lab): I thank my hon. Friend for securing this debate, and for the way it has been conducted at the end of quite a long day. I have been a proud champion of the White Ribbon campaign for many years—it is based in my constituency. Key to that campaign is the idea that it starts with men taking responsibility for how they and their friends act. In this place, our job is to legislate. Does my hon. Friend agree that part of that job is ensuring that we get education right?

At the moment, the education system does not do enough to address this, and we can see that in the results. UK Feminista stats show that almost four in 10 girls who go to mixed schools have been sexually harassed while at school. That is not acceptable. Children cannot learn if they are in fear. Human beings should have the right to live without fear. That is what I want to see in this country, in our education system and throughout society.

Emily Darlington: I absolutely agree with my hon. Friend, who is a big champion on this issue, not least with White Ribbon UK being in his constituency.

I want to move on to that subject. What do we do to make sure we challenge this? The work that the Government are doing is to challenge this through the law and the courts, but it is up to us to challenge it in our communities. We are role models in our communities. That is why I am proud to have led Milton Keynes to become the first White Ribbon city.

Jo White (Bassetlaw) (Lab): I thank my hon. Friend for securing this debate. This is so important for how we behave both as a society and in this House.

I have tabled an early-day motion calling for Disclosure and Barring Service checks for all Members of both Houses, as I think this would lead to greater transparency and openness. It would hopefully make us all feel safer in the corridors of power but, more importantly, it would give the institutions we visit, such as care homes and schools, much greater confidence in who they are letting through their doors. Would my hon. Friend support such a proposal?

Emily Darlington: I thank my hon. Friend, who I know cares deeply about this issue. I see the value in ensuring there is no fear when a Member of Parliament visits. People should always be able to have confidence in us around the elderly, children and women in our constituencies.

The theme of this year's White Ribbon Day is "It starts with men." Not all men are violent, but all men can help end violence against women and girls. I thank some of the men who have spoken on this issue recently, and who are paving the way as incredible role models for other men. My hon. Friend the Member for Calder Valley (Josh Fenton-Glynn) has worked tirelessly on this issue, my hon. Friend the Member for Blackpool South (Chris Webb) spoke passionately at the White Ribbon Day reception, and many others spoke in the Westminster Hall debate and have asked questions in this House.

It starts with us in this House. When Members fall short, it is right that we, the men and women of this House, call it out. Through the Modernisation Committee and other initiatives, such as DBS checks, I hope we can determine whether Members with violent criminal records have been elected to this House.

Alison Hume (Scarborough and Whitby) (Lab): Refuges offer protection from perpetrators, time to recover from abuse and a range of support to enable survivors to rebuild their lives, yet 61% of refuge referrals in England last year had to be declined due to lack of capacity. Scarborough and Whitby has the highest rate of recorded domestic incidents in North Yorkshire, but it has no refuge. Does my hon. Friend agree that the refuge sector needs more support?

Emily Darlington: I absolutely agree with my hon. Friend. There are far too few refuges, and those that exist often have too few beds and are often not appropriate for the kind of care and support that both survivors and their children need. I would like to see more examples like the purpose-built refuge in Milton Keynes, which provides care and counselling for every family member who needs to flee. However, achieving this will require more support from both local authorities and the Government. We must ensure that best practice is shared and that funding is in place.

Excuses have been made for far too long. "I was drunk." "Her skirt was short." "Her heels were high." "It was a teenage indiscretion." We must remember that our behaviour, our words and our actions are being watched. We have the opportunity to turn the tide for the 50% of the population who are scared to walk down the street, to attend a festival, to go for a run or even to go home.

The statistics on violence against woman and girls make too many women feel like it is inevitable that something will happen to them, even if it has already happened to them before. To them, it feels like only a matter of time. It is up to every Member of this House, women and men, to hold themselves up as an example of how real men behave and how women deserve to be treated.

2.54 pm

The Parliamentary Under-Secretary of State for the Home Department (Jess Phillips): I thank my hon. Friend the Member for Milton Keynes Central (Emily Darlington) for bringing forward this debate on such an important issue, and for what she has called the debate—it may not have been noted by anyone other than the eagle-eyed—which refers to "violence by men against women". I noted it and appreciate it, because men's violence against women and girls ruins lives on a truly terrible scale. It must be treated as a national emergency. It is a high-harm and high-volume crime which, because of the high volume, is difficult to grapple with, but we are absolutely determined to do that.

The data tells us that crimes such as domestic abuse, stalking, rape and other sexual offences disproportionately affect women. We also know that these crimes are predominantly, though not exclusively, committed by men. We have committed to halving violence against women and girls in the next decade. I will refer to some of the steps we are taking, although it is very nice for a Minister when all the steps we are going to take are mentioned in the preceding speech. I appreciate that. The steps include addressing the root causes, underlying behaviours and attitudes that cause violence against women and girls, and ensuring perpetrators are brought to justice. The femicides my hon. Friend highlighted when she began her speech tell the story better than any of us could. They are harrowing and each one a tragedy.

To say a positive thing, this new Parliament behaved beautifully in the previous debate and I feel proud today to call myself a parliamentarian. Mr Speaker, I do not know how you do it, because I literally cannot identify half the new Members of Parliament! The amount of men, from all parties, I have heard speaking up on violence against women and girls since I have been in my ministerial position has been a real sea change. The theme of this year's White Ribbon Day, referred to by my hon. Friend the Member for Calder Valley (Josh Fenton-Glynn), is "It starts with men". I have really, really felt that. I doff my cap to the hon. Member for Strangford (Jim Shannon), who has been in pretty much every debate I have been in on this subject. I really do feel like there has been quite a tide-turning in this regard, and it is really lovely to see here today men and women together speaking up on this issue.

We all know that domestic abuse is often a hidden crime that is not reported to the police. That is not acceptable. Victims deserve to feel safe and for justice to be upheld. In addition to relentlessly pursing perpetrators, it is also essential that we prevent reoffending and ensure that there is a comprehensive approach to perpetrators, from early intervention to targeting the most prolific and repeat offenders. This is why, as I outlined earlier—actually, I did not outline them; my hon. Friend the Member for Milton Keynes Central outlined some of the things the Government are going to do—we have implemented a series of bold measures designed to strengthen the police response to violence against women and girls, and protect victims and hold perpetrators to account.

Sarah Dyke: After a case of domestic abuse, my constituent dealt with over two years of delay before eventually the CPS decided not to proceed with the case, as the perpetrator had not carried out any further cases. With that in mind, does the Minister agree that we must address delays in domestic abuse cases and referrals from the police to the CPS, as they pose a unique risk to women's safety?

Jess Phillips: I absolutely agree. I think everybody sat in this debate could probably refer to a case in their own constituency with similar delays. In my role, I work very closely with both the police and the CPS to try to bottom out the issues causing some of those delays—other than the general degradation of our justice system—and to try to make improvements where we can. The attrition rate of victims dropping out is currently one of the

[Jess Phillips]

biggest barriers to us holding people to account. And who could blame a person for dropping out after being made to wait? I totally agree with the hon. Lady.

As part of our mission to halve violence against women and girls in a decade, we will ask police to relentlessly pursue those perpetrators who pose the greatest risk to women, and to use all the tools at their disposal to protect victims and get dangerous offenders off our streets. We will work with police to develop a national framework that uses data-driven tools and algorithms to track and target high-harm offenders involved in domestic abuse, sexual assault, harassment and stalking. In addition to the relentless pursuing of perpetrators, it is also essential that we prevent reoffending and, with that, have a truly comprehensive approach to deal with perpetration.

Many hon. Members in interventions mentioned brilliant organisations in their constituencies. I am delighted to hear that people have those—time was, there were not brilliant organisations all across the country. We must ensure that we maintain those brilliant services, which are so vital for helping keep victims safe.

I turn to the attitudes that my hon. Friend the Member for Milton Keynes Central talked about, and specifically the attitudes of young men. I am the mother of two teenage boys. One is about to be not a teenager but an actual real adult—I mean, he's not paying me any rent yet. *[Laughter.]* The data that she read out does not surprise me.

I think we always felt that there would be progress, with the "It's just a domestic" attitudes gradually getting better with time. But I have been alarmed by what we see in the attitudes, perpetration and victimisation data, which is that currently this crime is trending young: the biggest growth area is those aged 16 to 19. All of us would think that that is a tragedy we had not seen coming; we thought that with the younger generation we would be able to program it out. I am afraid to say that that has not been done, so prevention and education will be fundamental to our approach. We will tackle the root causes of these crimes, including supporting our education system to teach children about respectful and healthy relationships and consent. The idea that just because someone matched with somebody else on an online app meant they were owed something is the weakest idea of consent that I have ever heard.

We know that domestic abuse is one of the main reasons why children come into contact with children's social care, and it is a feature in more than half the serious incidents reported to the child safeguarding practice review panel. We know that those who experience abuse before the age of 16 are more likely to go on to be victims or perpetrators in adulthood. That is why prevention has to be the absolute cornerstone of the Government's actions going forward.

The Government are currently reviewing the content of the relationships, sex and health education curriculum. The Secretary of State for Education has been clear that children's wellbeing must be at the heart of guidance for schools. As such, the Government will look carefully at the consultation responses and discuss with stakeholders and consider the relevant evidence before setting out the next steps.

I express my gratitude once again to my hon. Friend for securing the debate and to all other hon. Members who are here on a Friday. Our mission is to halve violence against women and girls in a decade. It is ambitious but essential, and we will not do it without everybody in the House—as well as everybody in this country—doing it together. The points raised in the debate have once more reaffirmed how vital this work is and reminded us of the responsibility that we bear to women and girls across the country. The Government remain steadfast in that commitment and will tackle these issues head-on. I look forward to collaborating with all colleagues, as I always have.

Question put and agreed to.

3.4 pm

House adjourned.

Written Statements

Friday 29 November 2024

BUSINESS AND TRADE

Comprehensive and Progressive Agreement for Trans-Pacific Partnership

The Minister for Trade Policy and Economic Security (Mr Douglas Alexander): On 27 and 28 November 2024, I attended the eighth meeting of the commission of the comprehensive and progressive agreement for trans-Pacific partnership in Vancouver, Canada, where a number of issues were considered by CPTPP Ministers.

Future accessions to CPTPP

At the meeting, a formal commission decision was taken to commence a CPTPP accession process with Costa Rica via establishment of an accession working group.

CPTPP Ministers have reaffirmed on several instances that CPTPP is open to accession requests by economies that can satisfy the "Auckland principles", namely;

> preparedness to meet the agreement's high standards;
>
> a demonstrated pattern of complying with trade commitments; and
>
> recognition that decisions are dependent on the consensus of the CPTPP parties.

Through extensive discussions and deliberations on all accession requests, the UK and other CPTPP members have identified that Costa Rica can satisfy the three Auckland principles. As such, in Vancouver, CPTPP Ministers formally decided to commence the accession process with Costa Rica and establish an accession working group.

This move demonstrates that CPTPP remains a living agreement, and one which is designed to expand and bring in new high standards economies. Over time this expansion process will grow the global reach of the agreement, creating further opportunities for CPTPP members.

It is expected that the first AWG meeting will take place in the first half of 2025, during Australia's year as CPTPP chair. The UK will continue to work with CPTPP members to consider and discuss the remaining accession requests in accordance with the Auckland principles, and the establishment of an AWG for Costa Rica will not prevent this process.

To ensure that interested stakeholders are provided the opportunity to feed in views on the accession process of Costa Rica, today the Department for Business and Trade will launch a period of public engagement that will run across eight weeks, closing on 24 January 2025. During this period, we will ask stakeholders what issues they would like us to consider when engaging in discussions on whether Costa Rica should join CPTPP and the terms on which they should join.

The link to the public engagement questionnaire can be found online at
https://ditresearch.eu.qualtrics.com/jfe/form/SV_2bnop4ZwgdoyNVk

CPTPP general review

In addition to discussing future accessions, CPTPP Ministers also discussed progress on the CPTPP general review during the meeting in Vancouver. The joint ministerial statement—known as the "Vancouver statement"—published following the meeting summarises the progress made in 2024, during the first phase of the general review, and sets out the forward workplan for 2025. In 2025 members will deepen their discussions on whether and how the agreement should be revised or updated to remain relevant to the trade and investment issues and challenges we all face today, including in a number of areas of particular interest to the UK. The Vancouver statement can be found online at
https://www.gov.uk/government/publications/cptpp-joint-ministerial-statement-in-vancouver-canada-28-november-2024

The Department for Business and Trade has also today published a factual summary of responses received to the public engagement period on the general review which was carried out from January to February 2024. These responses continue to inform our ongoing engagement in the general review.

Entry into force

CPTPP Ministers at the meeting also warmly welcomed the impending entry into force of the agreement for the UK. In that vein, I would like to take this opportunity to confirm that the UK will accede to CPTPP on 15 December 2024 and that the agreement will come into force on this date with Japan, Singapore, Chile, New Zealand, Vietnam, Peru, Malaysia and Brunei. Australia also recently ratified the UK's accession protocol, on 25 October 2024, which means the agreement will enter into force with Australia on 24 December 2024. The deal will come into force with the remaining parties 60 days after they each ratify.

When the UK accedes, the CPTPP will become a truly global trade deal, bringing new opportunities for British businesses, supporting jobs across the entire UK, and shaping the future of international trading rules.

[HCWS267]

CULTURE, MEDIA AND SPORT

BBC Funding Model: Licence Fee and Simple Payment Plan

The Secretary of State for Culture, Media and Sport (Lisa Nandy): The Government are today providing an update on the short and long-term funding of the BBC.

The BBC is a vital British asset and makes a huge contribution to lives up and down the country. It supports our democracy, brings our communities together, and helps to shape and define our nation through telling stories about the lives of people in all parts of the UK. Continuing to make that contribution, and deliver the obligations placed upon it, requires that the BBC receives ongoing and sustainable public funding.

As the media landscape undergoes the next generational shift, the BBC too must adapt and be supported to do so. The forthcoming charter review is a key opportunity to set the BBC up for success long into the future. It will look at a range of issues and, as a priority for this Government, will start a national conversation to make sure the BBC truly represents and delivers for every person in this country. Charter review will also look to uphold the BBC's independence and ensure that it maintains the trust of the public.

As we address these vital issues about the future form of the BBC, we must also ensure that there is a sustainable funding model that is fair for those who pay for it. The Government are keeping an open mind about the future of the licence fee, but we are clear that the BBC's funding and its operation are inseparable. As such, we will not be progressing the BBC funding model review set up by the previous Government, and we are disbanding the expert panel set up to support that review, to whom we are grateful for their previous input.

In its place, the Government will be taking forward this issue as part of the charter review process, since what the BBC does and its future role are fundamentally influenced by how it is funded. We firmly believe that the unique obligations placed on the BBC demand continued, sustainable public funding to support its vital work. We will work closely with the BBC, and engage with other broadcasters, stakeholders across the creative industries as well as the British public to inform our thinking. This will include the opportunity for stakeholders and audiences across the country to respond to the charter review public consultation before the new charter comes into effect in 2028.

The charter review will be about ensuring the BBC thrives well into the future and can command the support of the people who pay for it. To achieve this aim, we must ensure the BBC is properly and fairly supported. The Government are determined to get the charter review right and future-proof the BBC, but we can only deliver this if the BBC is on a stable financial footing for the remainder of this charter period. We will always take decisions on funding to provide certainty and stability to the BBC, reflecting our understanding of the pressures it faces, and ensuring those decisions deliver the best outcomes for licence fee payers.

To provide stability to the BBC and S4C over the remainder of this charter period, the licence fee will increase in line with CPI inflation, as required by the licence fee settlement agreed by the last Government in 2022. This means a £5 increase per household to £174.50 from April 2025—less than the £10.50 increase in the previous year. Based on our assumptions on future TV licence uptake, this increase will provide around £75 million more in licence fee income to support the BBC and S4C in delivering their essential public service remits, allowing them to continue to deliver world-class, educational and engaging programming.

This increase represents a return to the approach taken at the start of this charter period, using the average of CPI from the previous October to September. To provide certainty to the BBC, S4C and the public, the Government confirm that we intend to use this same approach for calculating uplifts in the remaining years of this charter period. We will introduce legislation to implement the April 2025 uplift when parliamentary time allows.

We have already set out concerns about the impact of TV licensing enforcement action on vulnerable households. While the Government strongly believe in public funding for the BBC, given the public good it serves, we are aware of the financial difficulties faced by some households, and committed to supporting them to spread the cost of the TV licence. For this reason the Government are also announcing today a significant extension to the simple payment plan.

For the BBC to be a truly national broadcaster, the BBC must be available even to those struggling. The simple payment plan is an existing scheme that helps households struggling to pay for their licence fee throughout the year. However, it is currently available to a limited number of households. We will introduce legislation, when parliamentary time allows, that BBC analysis suggests could double the number of households in financial hardship benefiting from the scheme to around 500,000 by the end of the charter period to support them to be able to access all the BBC offers. This forms part of a wider discussion I am having with the BBC and Ministry of Justice on how we can collectively reduce the impact of TV licensing enforcement action on women and vulnerable people.

[HCWS269]

DEFENCE

Contingent Liability Continuation: Ukraine

The Minister for the Armed Forces (Luke Pollard): I wish to inform the House that I am today laying a departmental minute to advise of an extension to an existing contingent liability associated with the provision of support to the armed forces of Ukraine.

Since the start of the Russia's illegal and unprovoked invasion, the UK has been at the forefront of international support to Ukraine, providing essential military capability to the armed forces of Ukraine. We have developed capabilities, working with UK industry, to increase the support to the armed forces of Ukraine to defend against the threat from Russia.

The departmental minute describes the contingent liability that the Ministry of Defence will hold, which will provide an indemnity for any sums—including any legal or other associated costs—that UK defence industry might be liable to pay in relation to legal action brought against them by a third party in respect of liabilities arising from any damage to property, injury or loss of life from any unforeseen malfunction of a system operated by the armed forces of Ukraine.

The MOD and other stakeholders are taking all reasonable measures to mitigate the risk of injury and or damage and Defence legal advisers assess the likelihood of any risk arising as low. The maximum contingent liability held against the MOD is unquantifiable and will remain for the full service life of the system.

It is usual to allow a period of 14 sitting days prior to accepting a contingent liability, to provide Members of Parliament an opportunity to raise any objections.

This notification confirms the intention to extend a contingent liability that was initially agreed in July, during the pre-election period when Parliament had been dissolved and the normal process for notification of reportable contingent liabilities could not be followed. Further details are provided in the departmental minute.

[HCWS268]

HEALTH AND SOCIAL CARE

HIV Action Plan: Monitoring and Evaluation Framework Report

The Parliamentary Under-Secretary of State for Health and Social Care (Andrew Gwynne): This Government are committed to ending new HIV transmissions within England by 2030. On 28 November, the Prime Minister made a significant down payment on this as he announced that emergency department opt-out testing for HIV will be extended to both extremely high and high prevalence areas during 2025-26, backed by £27 million of funding from the Department's budgets, further confirming our determination.

I am pleased to update the House on the publication of the third annual report, "HIV Action Plan monitoring and evaluation framework 2024 report". This report provides an annual overview to Parliament of the Government's progress towards no new HIV transmissions within England by 2030, as committed to in the 2021 HIV action plan.

We are making progress towards our shared goals, and we should be encouraged by some of the highlights from the report.

> HIV testing in sexual health services increased by 8% from 2022 showing greater rises in some key population groups, such as gay, bisexual and men who have sex with men where a 36% increase can be observed. This is coupled by a substantial progress to reduce new HIV diagnoses first made in England between 2019 and 2023, particularly among the same population group.
>
> Overall, new HIV diagnoses first made in England fell by 12% from 2,801 in 2019 to 2,451 in 2022. However, this figure rose by 15% to 2,810 in 2023.
>
> The blood borne virus opt-out testing in emergency department programme has been a great success and has helped us identify a significant proportion of new HIV diagnoses in 2023.
>
> England continues to be one of the few countries in the world officially meeting the 95-95-95 targets when using the global measurement methods. However, in response to stakeholders' suggestions, UKHSA adjusted the UNAIDS 95-95-95 targets, for the first time, so that they also account for people diagnosed but not in active HIV care and people for whom information on viral suppression was not reported. This new approach shows UNAIDS 90-90-90 goals were met in England in 2023 and partially met for the UNAIDS 95-95-95 goals, with 96% of all those living with HIV being diagnosed, 94% of those diagnosed receiving treatment, and 92% of those treated being virally suppressed and thus unable to pass on the virus.
>
> Due to success in HIV treatment, over half of people living with HIV are over the age of 50.

However, there is more work to be done to achieve our shared ambitions.

> Inequalities are widening in access to HIV prevention interventions, treatment and ongoing care, quality of life and stigma across most demographic characteristics, in particular, age, ethnicity, gender identity and exposure. For example, among men exposed through sex with men, HIV diagnoses fell by 35% amongst white men between 2019 and 2023, whilst in men from ethnic minority backgrounds, there was an increase of diagnoses from 26% in 2019 to 33% in 2023.
>
> Similarly, there has been a significant increase in identifying need for and initiation of HIV pre-exposure prophylaxis (or PrEP): highest in white GBMSM and lowest in people from ethnic minority groups such as black African and black Caribbean.

As we reach the later stages in ending transmission, it is likely that identifying everyone living with the virus and narrowing inequalities will become more challenging. Our approach relies therefore on concerted efforts across the whole system.

The Department of Health and Social Care, the UK Health Security Agency, NHS England and a broad range of system partners in consultation with people living with HIV, their friends and families and the voluntary and community sector, are considering evidence from this report and working together to develop a new HIV action plan that will address these challenges. We aim to publish the plan in summer 2025.

I will keep Parliament updated on our progress and trust you will continue to support our shared goal of becoming the first country in the world to end HIV transmission.

[HCWS270]

WRITTEN STATEMENTS

Friday 29 November 2024

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