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PARLIAMENTARY DEBATES

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Friday 16 May 2025

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The House met at half-past Nine o'clock

PRAYERS

[MR SPEAKER *in the Chair*]

9.34 am

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

Consideration of Bill, as amended in the Public Bill Committee

9.35 am

Mr Speaker: Before we begin, I would like to say a few words about today's proceedings. New clauses and amendments are grouped in two groups for debate to enable two clear and coherent debates on aspects of the Bill. I will shortly call the Member in charge to move her new clause 10. Debate on the first group will take place on the question that new clause 10 be read a Second time. If that question is agreed to, I am minded to select amendment (a) to new clause 10 in the name of Rebecca Paul for separate decision.

We have more than 90 Members who have indicated that they wish to speak in the first debate, but not all hon. Members will be called. It is not customary to impose a speech time limit on a private Member's Bill, but I hope that Members in charge of the Bill, and the speakers after them, will restrict themselves in the early part of the debate to no more than 15 minutes in the first instance, including taking interventions. The time limit will have to drop accordingly thereafter, and the Chair will review that guidance as the debate progresses. We 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 time limit, but I would rather colleagues help each other. This is a very important debate that divides in different ways. Today is an opportunity primarily for Back Benchers. I do not expect to call Front Benchers to speak until at least 1.30 pm.

New Clause 10

NO OBLIGATION TO PROVIDE ASSISTANCE ETC

"(1) No person is under any duty to participate in the provision of assistance in accordance with this Act.

(2) No registered medical practitioner is under any duty to become—

(a) the coordinating doctor in relation to any person, or

(b) the independent doctor in relation to any person.

(3) No registered medical practitioner, other than the coordinating doctor or the independent doctor, is under any duty to perform any function under or in connection with this Act other than—

(a) a function relating to the giving of notifications, or

(b) a function relating to the recording of matters in a person's medical records.

(4) No health professional or social care professional is under any duty to respond when consulted under section 11(3)(b) (requirement for assessing doctor to consult professional with relevant qualifications or experience).

(5) No registered pharmacist or registered pharmacy technician is under any duty to participate in the supply of an approved substance to a registered medical practitioner for use in accordance with section 23.

(6) No person is under any duty to—

(a) act as a witness under this Act, or

(b) act as a proxy under this Act.

(7) Nothing in this section affects—

(a) any duty relating to the giving of notifications under this Act or the recording of matters in a person's medical records,

(b) any duty relating to a requirement to keep records or to provide information, or

(c) any duty of a professional to respond to enquiries made under section 11(2)(b) (enquiries by assessing doctor) relating to health or social care the professional is providing, or has recently provided, to a person seeking assistance under this Act.

(8) Schedule (Protection from detriment) amends the Employment Rights Act 1996 to make provision to protect employees and other workers from being subjected to any detriment for—

(a) exercising (or proposing to exercise) a right under this section not to participate in an activity or perform a function, or

(b) participating in the provision of assistance in accordance with this Act or performing any other function under this Act.

(9) In this section—

(a) a reference to a duty includes any duty, whether arising from any contract, statute or otherwise;

(b) "registered pharmacist" and "registered pharmacy technician" have the same meaning as in the Pharmacy Order 2010 (S.I. 2010/231) (see article 3 of that Order)."—*(Kim Leadbeater.)*

This new clause, intended to replace clause 28, expands the protection currently provided by that clause by broadening the persons to whom it applies and the functions to which it relates; and it introduces NS1 which makes provision for enforcement of the right not be subject to detriment in connection with the Bill

Brought up, and read the First time.

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

Mr Speaker: With this it will be convenient to discuss the following:

Amendment (a) to new clause 10, after subsection 8(b), insert—

"(8A) Nothing in Schedule (Protection from Detriment) prevents an employer who has chosen not to participate in the provision of assistance in accordance with this Act from prohibiting their employees or workers from providing such assistance in the course of their employment or work with that employer."

This amendment ensures that employees who work for an employer who had chosen not to provide assisted dying cannot do so whilst working for that employer.

New clause 11—*Replacing the coordinating or independent doctor where unable or unwilling to continue to act*—

“(1) This section applies where—

(a) after a first declaration has been witnessed by the coordinating doctor, that doctor is unable or unwilling to continue to carry out the functions of the coordinating doctor, or

(b) after a referral is made under section 9(3)(c) (including a referral to which section 12(4) applies), but before a report under section 10 has been made by virtue of that referral, the independent doctor is unable or unwilling to continue to carry out the functions of the independent doctor,

and in this section such a coordinating or independent doctor is referred to as “the outgoing doctor”.

(2) The outgoing doctor must as soon as practicable give written notice of their inability or unwillingness to continue to carry out their functions under this Act to—

(a) the person seeking assistance,

(b) the Commissioner, and

(c) if the outgoing doctor is the independent doctor, the coordinating doctor.

(3) Any duty or power of the outgoing doctor under this Act that arose in consequence of the declaration or referral mentioned in subsection (1) ceases to have effect from the time the outgoing doctor complies with subsection (2); but this does not apply to any duty under subsection (8) or (9).

(4) The Secretary of State may by regulations make provision relating to the appointment, with the agreement of the person seeking assistance, of a replacement coordinating doctor who meets the requirements of section 7(5) and who is able and willing to carry out the functions of the coordinating doctor.

(5) Regulations under subsection (4) may, in particular, make provision to ensure continuity of care for the person seeking assistance despite the change in the coordinating doctor.

(6) Where the independent doctor gives a notice under subsection (2)—

(a) a further referral may be made—

(i) under section 9(3)(c) (if section 12 does not apply), or

(ii) where section 12 applies, under subsection (2) of that section, and

(b) the registered medical practitioner to whom that referral is made becomes the independent doctor (replacing the outgoing doctor) and sections 10 to 12 (and this section) apply accordingly.

(7) Subsections (8) and (9) apply where the coordinating doctor—

(a) gives a notice under subsection (2) to the person seeking assistance, or

(b) receives a notice under that subsection given by the independent doctor in relation to the person seeking assistance.

(8) Where the coordinating doctor is a practitioner with the person’s GP practice, the coordinating doctor must, as soon as practicable, record the giving of the notice in the person’s medical records.

(9) In any other case—

(a) the coordinating doctor must, as soon as practicable, notify a registered medical practitioner with that practice of the giving of the notice, and

(b) the practitioner notified under paragraph (a) must, as soon as practicable, record the giving of the notice in the person’s medical records.”

This new clause makes provision about the replacement of the coordinating doctor or the independent doctor where the doctor is unable or unwilling to continue to carry out their functions under the Bill.

New clause 12—*Report where assistance not provided because coordinating doctor not satisfied of all relevant matters*—

“(1) This section applies where a person is not provided with assistance under section 23 because the coordinating doctor is not satisfied as to all of the matters mentioned in section 23(5).

(2) The coordinating doctor must make a report which—

(a) sets out the matters as to which they are not satisfied, and

(b) contains an explanation of why they are not satisfied of those matters.

(3) The Secretary of State may by regulations make provision about the content or form of the report.

(4) The coordinating doctor must give a copy of the report to—

(a) the person,

(b) if the coordinating doctor is not a practitioner with the person’s GP’s practice, a registered medical practitioner with that practice, and

(c) the Commissioner.”

This new clause (intended to be inserted after Clause 27) requires the coordinating doctor to produce a report where assistance is not provided because they are not satisfied of all of the matters mentioned in Clause 23(5).

New clause 1—*No health professional shall raise assisted dying first*—

“No registered medical practitioner or other health professional shall raise the subject of the provision of assistance in accordance with this Act with a person unless that person has first raised it.”

New clause 2—*No health professional shall raise assisted dying with a person under 18*—

No registered medical practitioner or other health professional shall raise the subject of the provision of assistance in accordance with this Act with a person under the age of 18.”

New clause 7—*Doctor independence*—

“(1) Any same two registered medical practitioners may not be involved in the assessment of any one person (whether as co-ordinating doctor or independent doctor) more than three times in any 12-month period.

(2) Where section 13 applies the Commissioner may authorise one additional instance in any relevant 12-month period.

(3) The Secretary of State may, by regulations, modify the time periods specified in subsections (1) and (2) if, in the reasonable opinion of the Secretary of State, such modification is—

(a) necessary to ensure the availability of assisted dying, and

(b) does not compromise the independence of the two assessments.”

This new clause limits the number of times two doctors can both act in the assessment of any one person to three times a year. It allows for the Commissioner to increase that limit in the case of death or incapacity of a doctor. Finally, the Secretary of State is given the power to modify that limit. Amendment 50 is consequential to this and ensures such regulations are made using the affirmative procedure.

New clause 9—*Standard of proof*—

“(1) Where a registered medical practitioner is required to be satisfied of a matter (other than under section 23(5)), the applicable standard of proof is a balance of probabilities but if they are not satisfied beyond reasonable doubt they must indicate in their report or statement that they are not so satisfied.

(2) Where an Assisted Dying Review Panel is required to be satisfied of a matter, the applicable standard of proof is beyond reasonable doubt.

(3) Where a registered medical practitioner is required to be satisfied of matters arising under section 23(5), the applicable standard of proof is beyond reasonable doubt.”

This new clause would require the co-ordinating and independent doctor to flag if they are unsure whether one of the eligibility requirements is met or not. It also requires that a panel has to be sure that all the eligibility requirements are met. Finally, it requires the doctor administering the lethal substance to be sure that the person has capacity, a clear settled and informed wish to end their life, and is acting voluntarily without coercion and pressure.

New clause 16—*Wish to end one's own life*—

"(1) A person does not have a wish to seek assistance to end their own life in accordance with this Act under section 5(5) if they are substantially motivated by—

(a) not wanting to be a burden on others or on public services,

(b) a mental disorder (including depression),

(c) a disability (other than the terminal illness),

(d) financial considerations, including lack of adequate housing,

(e) lack of access, or delayed access, to treatment or other service which a public authority is required (or can reasonably be expected to) provide, or

(f) suicidal ideation."

This new clause ensures that a wish to end one's own life that is substantially motivated by the factors listed in the amendment does not qualify for the provision of assistance under this Act.

New clause 17—*No detriment for care home or hospice not providing assistance*—

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

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

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

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

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

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

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

New clause 18—*Care Homes and Hospices to decide their own involvement*—

"(1) Nothing in this Act prevents any regulated care home or hospice from deciding whether (and if so to what extent) it wishes to provide assistance under this Act or to allow it on its premises."

This new clause ensures that care homes and hospices are free to decide whether and to what extent they wish to provide assistance under this Act or allow it on their premises.

Amendment 80 to clause 2, page 2, line 4, leave out "and" and insert—

"(aa) As a result of that illness or disease the person is experiencing (or will likely experience) severe pain and discomfort that cannot be reasonably relieved to the person's satisfaction through palliative care, and".

This amendment requires that, in order to qualify, the terminal illness causes (or is likely to cause) severe pain and discomfort that cannot reasonably be relieved through palliative care.

Amendment 18, page 2, line 6, leave out from "expected" to end.

This amendment would remove the six-month time limit for a person to be eligible for an assisted death.

Amendment 4, page 2, line 6, leave out "within 6 months" and insert—

"(i) in the case of a neurodegenerative illness or disease, within 12 months; or

(ii) in the case of any other illness or disease, within 6 months."

Amendment 14, page 2, line 6, at end insert—

"(1A) A person who would not otherwise meet the requirements of subsection (1) shall not be considered to meet those requirements solely as a result of voluntarily stopping eating or drinking."

This amendment means that someone who is not terminally ill within the meaning of subsection (1) cannot bring themselves within that definition by voluntarily stopping eating or drinking or both.

Amendment 38, page 2, line 6, at end insert—

"(1A) A person who would not otherwise meet the requirements of subsection (1) shall not be considered to meet those requirements solely as a result of refusing standard medical treatment or taking any action intended to bring about a state of terminal illness."

This amendment clarifies that an individual who is not already terminally ill under the definition in subsection (1) cannot qualify by refusing standard treatment or taking steps to induce a terminal condition.

Amendment 55, page 2, line 8, leave out ", disease or medical condition" and insert "or disease".

This amendment aligns the wording of subsection (2) with the wording used in subsection (1) (which defines what it means to be "terminally ill" for the purposes of the Bill).

Amendment 81, page 2, line 16, leave out clause 3.

Amendment 24 to clause 3, page 2, line 18, at end insert

"except that section 1(2) of that Act shall not apply".

This amendment would disapply the presumption that a person has capacity unless the opposite is established.

Amendment 17, page 2, line 18, at end insert—

"(2) For the purposes of the assessment of a person's capacity under this Act the information relevant to the decision as specified under section 3(1)(a) of the Mental Capacity Act 2005 must include, but is not limited to—

(a) the options for care and treatment of the terminal illness, including—

(i) the extent of prognostic certainty of their illness or condition, and

(ii) the likely effects on day-to-day functioning, symptom management, and pathway to and experience of death of—

(A) relevant and available care and treatment including palliative care, hospice or other care,

(B) withdrawal or absence of care and treatment,

(b) the likely pathway to and experience of death, including relevant risks of complications, following proceeding to self-administer a substance to end their own life under the provisions of this Act,

(c) a decision to proceed under this Act does not prevent or make unavailable any care and treatment provision that would normally be provided,

(d) the person's decision to proceed under this Act must be theirs alone and not bound or directed by the views or decisions of others,

(e) the person is able to change their mind at any stage of the process for requesting assistance to end their own life under the provisions of this Act, regardless of previous decisions,

(f) a decision to proceed under this Act is a decision to self-administer a substance to end their own life,

(g) the self-administration of such a substance is not a medical treatment for their terminal illness but a personal choice concerning life and death, and

(h) relevant legal consequences from proceeding with a request for assistance to end their own life, including life insurance and categorisation of death certification."

Amendment 2 to clause 5, page 3, line 5, leave out subsection (2).

This amendment is consequential to NC1.

Amendment 101, page 3, line 7, after "person" insert—

", unless the person has Down syndrome or a learning disability, in which case a registered medical practitioner must not initiate, suggest, or raise the matter of assisted dying with that person".

This amendment would disallow medical practitioners from initiating a conversation about assisted dying with a person who has Down Syndrome or a learning disability.

Amendment 102, page 3, line 12, at end insert—

"(3A) Before conducting a preliminary discussion under subsection (2) the registered medical practitioner must ensure that the person has no remediable suicide risk factors which pose a significant risk to their life."

This amendment would mean that a preliminary discussion could not be held with someone who has remediable suicide risk factors which pose a significant risk to their life.

Amendment 26, page 3, line 20, leave out ", hospice".

This amendment leaves out reference to a hospice, since this is a setting for the provision of palliative care.

Amendment 56 to clause 7, page 4, line 14, at end insert—

"(2A) The coordinating doctor must give a copy of the first declaration to the Commissioner as soon as reasonably practicable after it has been made."

This amendment requires the coordinating doctor to give a copy of the first declaration to the Commissioner.

Amendment 57, page 5, line 14, leave out "include training about" and insert "provide that the practitioner must have had training about the following".

This clarifies that the obligation under subsection (7) is to specify training about certain matters.

Amendment 58, page 5, line 18, leave out—

"specific and up-to-date training on".

This clarifies that the training is to be about adjustments and safeguards for autistic people and person with a learning disability (rather than training about training about such matters).

Amendment 59, page 5, line 19, at end insert—

"(d) domestic abuse."

This is a drafting change (moving the duty for the regulations to require the coordinating doctor to have received training on domestic abuse so that it is located with other similar duties). See also amendment 74, which defines "domestic abuse" for the purposes of the Bill.

Amendment 87 to clause 9, page 6, line 2, at end insert—

"(1A) The coordinating doctor must take all reasonable steps, including by asking the person, the Commissioner, and the relevant Chief Medical Officer, to find out whether that person has previously made a first declaration.

(1B) If it appears that the person has previously made a first declaration, the coordinating doctor must obtain all relevant reports relating to that first declaration and, if no reports are available, must speak to the doctor who witnessed it unless that is not reasonably possible."

Amendment 45, page 6, line 3, leave out from "person" to end of line 16 and insert—

"(1) On completion of the first declaration, the coordinating doctor must convene a clinical panel to carry out the first assessment.

(1A) the "first assessment" is an assessment to determine a person's eligibility for assistance under this Act.

(1B) The clinical panel must consist of—

(a) a registered social worker,

(b) a registered psychiatrist,

(c) a palliative care consultant, registered on the GMC Specialist Register,

(d) a doctor who is—

(i) a consultant in a specialty of the patient's diagnosis, if the coordinating doctor is a GP, or

(ii) a GP, if the co-ordinating doctor is a consultant, and

(e) the coordinating doctor.

(1C) All registered health and social worker professionals on the clinical panel must have—

(a) received relevant training as determined by the Secretary of State, and

(b) opted in to determine that they are eligible to be on that panel.

(1D) The Secretary of State may by regulations establish a system for registered health and social worker professionals to opt in under subsection (1B).

(1E) For the first assessment, the clinical panel must establish—

(a) why the person wants to end their life through an assisted death and the alternatives they have considered,

(b) the person's understanding of their disease or illness and how this can be palliated,

(c) whether there have been any intrinsic or extrinsic coercion which has led to the person seeking an assisted death,

(d) what support is available to the person and their carers for the duration of the person's life,

(e) that the person—

(i) is terminally ill,

(ii) has capacity to make the decision to end their own life,

(iii) was aged 18 or above at the time the first declaration was made,

(iv) is in England and Wales,

(v) is an ordinary resident in England and Wales and has been so resident for at least 12 months ending with the date of the first declaration,

(vi) is registered as a patient with a general medical practice in England or Wales,

(vii) has a clear, settled and informed wish to end their own life,

(viii) made the first declaration voluntarily and has not been subject to coercion or pressured by any other person into making it,

(ix) is secure in their decision, and

(x) is not having their decision making impacted by their mental health.

(1F) The clinical panel must provide the person with information on the support available for the duration of their life, including future care planning.

(1G) The members of the clinical panel must meet with the patient.

(1H) For the purposes of subsection (1G), the person may meet the clinical panel members separately or as a group, depending on the person's wishes.

(1I) When all assessments are complete all the members of the clinical panel must meet to discuss the patient's safety, eligibility and care plan, including referral to specialist services.

(1J) Should the panel come to the view that the criteria set out in subsection (1E)(e) are not met, they must prepare a written statement and a member of the panel must meet the patient to discuss their findings.

(1K) When presenting the report under subsection (1J), the member of the panel must discuss with the person—

(a) the options available to the person, which can include the provision of more information, and

(b) access to the clinical or other support they require."

Amendment 30, page 6, line 8, at end insert—

"(ca) has relevant and available palliative care options,".

This amendment would mean that someone is only eligible for assistance in ending their own life under this Act if they have relevant and available palliative care options.

Amendment 46, page 6, line 27, leave out from "if" to "refer" in line 28 and insert—0 "the clinical panel is satisfied of all the matters listed in subsection (1E)(e),".

Amendment 60, page 7, line 1, at end insert—

"(6) Where—

(a) a referral is made under subsection (3)(c),

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

(c) no report under section 10 has been made by virtue of the referral,

a further referral may be made under subsection (3)(c).

(7) Where a referral is made to a registered medical practitioner by virtue of subsection (6), that practitioner becomes the independent doctor (replacing the registered medical practitioner to whom a referral was originally made) and sections 10 to 12 and (Replacing the coordinating or independent doctor where unable or unwilling to continue to act) apply accordingly."

This amendment makes provision, corresponding to the provision in clause 12 about the death or illness of a doctor from whom a second opinion is sought, for a further referral to be made where, before reporting, the independent doctor dies or through illness is unable or unwilling to act.

Amendment 32 to clause 10, page 8, line 6, at end insert—

"(aa) is a practitioner approved as having special experience in the diagnosis or treatment of mental disorder for the purposes of subsection (2) of Section 12 (General provisions as to medical recommendations) of the Mental Health Act 1983,"

This amendment would require the independent doctor to have special experience in the diagnosis of mental disorder.

Amendment 61, page 8, line 22, leave out "include training about" and insert "provide that the practitioner must have had training about the following".

This clarifies that the obligation under subsection (10) is to specify training about certain matters.

Amendment 62, page 8, line 25, at end insert "(c) domestic abuse."

This is a drafting change.

Amendment 51 to clause 11, page 9, line 10, at end insert—

"(v) whether, according to any reasonable body of medical or scientific opinion, there are risks of complications (including pain), and what those complications are, from the substance to be ingested;"

This amendment requires doctors to inform persons seeking assisted dying of any reasonable medical and scientific opinion according to which the lethal drugs have a risk of complication and what those complications are.

Amendment 33, page 9, line 24, at end insert—

"(fa) ask the person whether they have discussed the request with their next of kin and other persons they are close to and, where they have not done so, discuss their reasons for not doing so."

This amendment would require the assessing doctors to ask the person whether they have discussed their request for an assisted death with family and friends, and to discuss their reasons if not, in order to decide whether to advise that they should do so under subsection (g).

Amendment 22, page 9, line 28, leave out from "must" to end of line 33 and insert— "consult such other health and social care professionals with qualifications in, or experience of, a matter relevant to the person being assessed, including but not limited to clinical, psychological and social matters."

This amendment would require the assessing doctor to consult other health professions and other persons as the assessing doctor sees fit on clinical, psychological and social matters relevant to the person.

Amendment 63, page 9, line 44, leave out ", disease or condition" and insert "or disease".

This amendment aligns the wording used here with the wording used in Clause 2(1) (which defines what it means to be "terminally ill" for the purposes of the Bill).

Amendment 64 to clause 12, page 10, line 40, leave out "section 10 and 11" and insert—

"sections 10, 11 and (Replacing the coordinating or independent doctor where unable or unwilling to continue to act)".

This amendment is consequential on NC11.

Amendment 65, page 11, line 3, at end insert—

"and section (Replacing the coordinating or independent doctor where unable or unwilling to continue to act)(6)(a)(ii)".

This amendment is consequential on NC11.

Amendment 47 to clause 14, page 11, line 33, at end insert—

"(2A) The Commissioner must give notice of the referral to any persons who are likely to have an interest in being notified by virtue of being persons properly interested in the welfare of the person to whom the referral relates, and other persons they are close to.

(2B) Those persons may either become parties to the proceedings before the panel or may give evidence to the panel without becoming parties, at the Panel's discretion.

(2C) The Commissioner must issue a practice direction relating to the matters in subsection (2A) and (2B)."

Amendment 48, page 11, line 33, at end insert—

"(2A) The Commissioner must give notice of the referral to the designated authority and make them a party to the proceedings.

(2B) The designated authority must send a representative or advocate to the panel who will be tasked to make all reasonable arguments to the panel for why a certificate of eligibility should not be granted.

(2C) The designated authority shall be one of the following as chosen by the Secretary of State in regulations—

(a) the Official Solicitor,

(b) the King's Proctor,

(c) the Attorney General, or

(d) any other body so designated by the Secretary of State."

Amendment 31 to clause 15, page 12, line 17, at end insert—

"(da) that the person has relevant and available palliative care options,".

This amendment, which is linked to Amendment 30 would mean that someone is only eligible for assistance in ending their own life under this Act if they have relevant and available palliative care options.

Amendment 5, page 12, line 29, at end insert—

"(j) that there are no psychological, social or environmental factors influencing the person to make the decision."

This amendment ensures that the panel must be satisfied that no psychological, social or environmental factors are influencing the decision of a person to seek assisted dying.

Amendment 6, page 12, line 33, leave out "may" and insert "must".

This amendment would require the panel to question the coordinating doctor or the independent doctor.

Amendment 7, page 12, line 35, leave out "may" and insert "must".

This amendment would require the panel to question the person seeking an assisted death.

Amendment 10, page 12, line 36, at end insert—

"(ba) must ask the person whether they have discussed the request with their next of kin and other persons they are close to and, where they have not done so, discuss their reasons for not doing so;"

This amendment would require the Voluntary Assisted Dying Panel to ask the person whether they have discussed their request for an assisted death with family and friends, and to discuss their reasons if not, in order to determine whether to grant a certificate of eligibility.

Amendment 8, page 12, line 38, at end insert—

"(ca) must consider hearing from and questioning—

(i) persons properly interested in the welfare of the person to whom the referral relates, and other persons they are close to; and

(ii) any other person who has provided treatment or care for the person to whom the referral relates in relation to that person's terminal illness;".

This amendment would require the panel to consider hearing from those with an interest in the welfare of the person and those who have provided treatment to them.

Amendment 11, page 13, line 4, leave out subsection (6) and insert—

"(6) If the panel is of the opinion that there are exceptional circumstances which justify not hearing from the person, then the duties under subsections (4)(b) and (4)(ba) do not apply."

This amendment is connected to Amendment 10.

Amendment 23, page 13, line 14, at end insert—

"(ca) where the person to whom the referral relates is under the age of 25, their next of kin;".

Amendment 49 to clause 16, page 13, line 23, leave out subsections (1) to (4) and insert—

"(1) The person applying for assisted dying, any parties to the proceedings, or the registered medical practitioners who are treating them may apply to the Commissioner for the Panel's decision to be reconsidered.

(2) Anyone with evidence, which was not before the Panel, showing that a certificate of eligibility should not have been issued may apply to the Commissioner for the Panel's decision to be reconsidered.

(3) The Commission must consider, without a hearing, whether an application under subsection (1) or subsection (2) raises an arguable case that the Panel's decision was—

(a) wrong, or

(b) unjust because of a serious procedural or other irregularity in the proceedings.

(4) Upon receiving an application under subsection (2) the Commissioner must—

(a) if satisfied that there is an arguable case that either of the criteria in subsection (3) are met, refer as soon as reasonably practicable the person's case to a different Assisted Dying Review Panel for a determination of whether either of the criteria in subsection (3) are met,

(b) in any other case, dismiss the application.

(5) If the new Assisted Dying Review Panel concludes that the either criterion under subsection (3) is met, they must consider the person's eligibility for a certificate of eligibility application afresh.

(6) The new Assisted Dying Review panel may consider whether either of the subsection (3) criteria are met and the fresh application under subsection (5) together.

(7) An assisted death must not take place for a person whose application for assisted dying is subject to the process under subsections (1) to (6) until the conclusion of that process."

Amendment 66, to clause 23, page 19, line 21, leave out "subsection (3)" and insert "subsection (2)".

This is a drafting change.

Amendment 67, page 19, line 32, at end insert—

"(6A) An approved substance may be provided to a person under subsection (2) by—

(a) preparing a device which will enable that person to self-administer the substance, and

(b) providing that person with the device.

In the case of an approved substance so provided, the reference in subsection (3) to the approved substance is to be read as a reference to the device."

This amendment clarifies how the clause works in cases where an approved substance is provided by preparing a device and providing a person with the device.

Amendment 68, page 19, line 36, leave out paragraph (b).

This amendment is consequential on amendment 67.

Amendment 91 to clause 26, page 21, line 22, leave out paragraph (a) and insert—

"(a) the person's full name, date of birth, sex, ethnicity, and last permanent address;

(aa) whether, immediately before death, the person had a disability within the meaning of section 6 of the Equality Act 2010 (other than a disability consisting of the illness or disease which caused the person to be terminally ill within the meaning of this Act);"

This amendment expands the duty as regards regulations about final statements so as to provide that certain additional information is included in final statements.

Amendment 52, page 22, line 28, leave out clause 28.

This amendment is consequential on NC10.

Amendment 16 to clause 28, page 22, line 35, insert—

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

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

Amendment 74 to clause 52, page 35, line 20, at end insert—

""domestic abuse" has the meaning given by section 1 of the Domestic Abuse Act 2021 (and accordingly includes behaviour that is controlling or coercive or that constitutes economic abuse);"

This amendment defines "domestic abuse" for the purposes of the Bill.

Amendment 75, page 35, line 31, at end insert—

""learning disability" has the meaning given by section 1(4) of the Mental Health Act 1983;".

This amendment defines "learning disability" for the purposes of the Bill.

New schedule 1—*Protection from detriment*—

"Schedule

1 The Employment Rights Act 1996 is amended as follows.

2 After section 43M insert—

"43N Provision of assistance under Terminally Ill Adults (End of Life) Act 2025

(1) A worker has the right not to be subjected to any detriment by any act, or any deliberate failure to act, by the worker's employer done on the ground that the worker has—

(a) exercised (or proposed to exercise) a right conferred on the worker under section (No obligation to provide assistance etc) of the Terminally Ill Adults (End of Life) Act 2025 (no obligation to provide assistance etc), or

(b) participated in the provision of assistance to a person to end their own life in accordance with that Act, or performed any other function under that Act, in accordance with that Act.

(2) Subsection (1) does not apply where—

(a) the worker is an employee, and

(b) the detriment in question amounts to dismissal within the meaning of Part 10.

(3) For the purposes of this section, and of sections 48 and 49 so far as relating to this section, "worker" and "employer" have the extended meaning given by section 43K."

3 (1) Section 48 (complaints to employment tribunals) is amended as follows.

(2) After subsection (1) insert—

"(1WA) A worker may present a complaint to an employment tribunal that the worker has been subjected to a detriment in contravention of section 43N(1)."

(3) In subsection (2), after "(1)" insert ", (1WA)".

4 (1) Section 49 (remedies) is amended as follows.

(2) In subsection (1), after "section 48(1)" insert ", (1WA)".

(3) In subsection (2), after "subsections" insert "(5YA),".

(4) After subsection (5) insert—

"(5YA) Where—

(a) the complaint is made under section 48(1WA),

(b) the detriment to which the worker is subjected is the termination of the worker's contract, and

(c) that contract is not a contract of employment,

any compensation must not exceed the compensation that would be payable under Chapter 2 of Part 10 if the worker had been an employee and had been dismissed for a reason specified in section 98C."

5 After section 98B insert—

"98C Provision of assistance under Terminally Ill Adults (End of Life) Act 2025

An employee who is dismissed is to be regarded for the purposes of this Part as unfairly dismissed if the reason (or if more than one, the principal reason) for the dismissal is that the employee—

(a) exercised (or proposed to exercise) a right conferred on the employee under section (No obligation to provide assistance etc) of the Terminally Ill Adults (End of Life) Act 2025 (no obligation to provide assistance etc), or

(b) participated in the provision of assistance to a person to end their own life in accordance with that Act, or performed any other function under that Act, in accordance with that Act."

6 In section 105 (redundancy), after subsection (2A) insert—

"(2B) This subsection applies if the reason (or, if more than one, the principal reason) for which the employee was selected for dismissal was one of those specified in section 98C."

7 In section 108 (qualifying period of employment), in subsection (3), after paragraph (aa) insert—

"(ab) section 98C applies,".

8 In section 205 (remedy for infringement of certain rights), after subsection (1) insert—

"(1XA) In relation to the right conferred by section 43N(1), the reference in subsection (1) to an employee has effect as a reference to a worker."

9 In section 230 (definitions of employees, workers etc) in subsection (6)—

(a) after "43K" insert ", 43N(3)";

(b) after "Part IVA" insert ", section 43N"."

This new Schedule amends the Employment Rights Act 1996 so as to provide remedies for persons subjected to detriment for exercising or proposing a right conferred by NC10 or for participating in the provision of assistance in accordance with, or performing any other function under, the Bill.

Amendment 78 to schedule 2, page 42, line 26, at end insert—

", or

(b) abstains from voting on such a decision."

This amendment ensures that a panel must not grant certificate of eligibility unless all members consider that such a certificate should be granted.

Amendment 79, page 43, line 7, at end insert—

"(2) As soon as reasonably practicable after making a decision, a panel must give the following a document containing its reasons for the decision—

(a) the person to whom the referral in question relates;

(b) the coordinating doctor in relation to the person;

(c) the Commissioner."

This amendment requires a panel to give the persons mentioned a document containing its reasons for any decision made by the panel.

Kim Leadbeater: It is a privilege to open the debate on this next important stage of the Terminally Ill Adults (End of Life) Bill. It seems a long time ago that we held the Second Reading debate in November on what many of us felt was a very proud day for Parliament, when we saw an emotional and passionate but largely respectful debate on a hugely important subject that means so much to so many people.

I know that there are a range of views on the subject of choice at the end of life, and today is not about revisiting the fundamental principle of assisted dying. Before I address the amendments in my name, as the sponsor of the Bill, I will make some brief introductory

[Kim Leadbeater]

comments on why we are here. Put simply, if we do not vote to change the law, we are essentially saying that the status quo is acceptable. Over recent months, I have heard hundreds of stories from people who have lost loved ones in deeply difficult and traumatic circumstances that show that that is clearly not the case. Too many have seen their terminally-ill loved ones take their own lives out of desperation or make the traumatic, lonely and costly trip to Switzerland, and then face a police investigation while dealing with their grief and loss.

John Whitby (Derbyshire Dales) (Lab): My hon. Friend mentioned many real stories influencing this debate. I will mention one more: my constituent Mick Murray, who is in the Public Gallery today. Mick helped two close friends, Bob and Ann, to make the painful journey to Dignitas. Both simply wanted to die at home with dignity and surrounded by loved ones; instead, they had to make that journey overseas at great cost and legal jeopardy. Mick said:

> "I helped them out of compassion — and I think that is what's missing from our current law."

Does my hon. Friend agree—

Mr Speaker: Order. We will set the example by following the rules of the House. We will have short interventions, not speeches. There are a load of other Members.

Kim Leadbeater: I thank my hon. Friend for that intervention. That was a very powerful point, if slightly long. There are people who face these really traumatic and difficult decisions every day, including Louise Shackleton, who I believe is also with us today.

Torcuil Crichton (Na h-Eileanan an Iar) (Lab): On a point of order, Mr Speaker. I thought this was a debate to discuss amendments, not a general debate.

Mr Speaker: It is, but I think this is the opening lead-in to the amendments. I will make that judgment call.

Kim Leadbeater: Thank you, Mr Speaker. If I may just finish that point—

Jim Shannon (Strangford) (DUP) *rose*—

Mr Speaker: Order. May I just say to people that if we are going to have continuous interventions, and if they continue to make the same intervention, they should not be shocked if they end up at the bottom of the list? I want to help people, because all this does is soak up time. Jim Shannon will be a good example.

Jim Shannon: Mr Speaker, I will always be at the end of the list, so it is important for me to make an intervention. The hon. Member for Spen Valley (Kim Leadbeater) set the scene very well on Second Reading, but since then things have changed. For instance, the Royal College of Psychiatrists has voiced strong concerns in opposition to the Bill about judicial oversight, robust protections against coercion and so on, as well as the effect it will have on vulnerable groups such as those with dementia, Down syndrome or mental illnesses. Does the hon. Lady not respect the viewpoints of my constituents who tell me that they are opposed to the Bill in principle and all the things that are coming forward? The new clause does not address the issues that the hon. Lady is referring to.

Kim Leadbeater: I thank the hon. Gentleman for that intervention and he is absolutely right that there are a range of views on this issue, and I am deeply respectful of that. I take all those points into consideration as we embark on this debate again today.

Perhaps most importantly, Mr Speaker, I have spoken to terminally ill people themselves over recent months. It is impossible to know what it must feel like to receive a terminal diagnosis and I have nothing but admiration for people who have bravely spoken about their personal situations, some publicly—including, of course, Dame Esther Rantzen—and others who have done so privately, many by emailing their MP. I know mine is not the only inbox full of such emails.

Jess Asato (Lowestoft) (Lab): Will my hon. Friend distance herself from the correspondence from Dame Esther Rantzen, who accused those of us who have concerns about the Bill of having undeclared religious beliefs? Many colleagues found that distasteful and disrespectful.

Kim Leadbeater: I thank my hon. Friend for that intervention. I have not seen those comments, but it is absolutely right that whatever our views are on this issue, we must remain respectful.

I also want to thank colleagues here in Parliament—MPs and indeed staff—who have shared their personal stories of loss with me over recent months. This is a really important point: these are real people with real stories, and they must always be at the heart of the debate.

Public support for assisted dying in this country has been consistently high for a long time now, and we have seen movement in jurisdictions around the world, including just this week in Scotland. I congratulate colleagues in Holyrood, particularly Liam McArthur MSP, for holding such a compassionate and respectful debate, which I hope we can emulate today.

It is right that we consider this change with great care, as we are doing today. But we should also remember, as with other big social changes such as giving women bodily autonomy on their reproductive rights or allowing gay—

Mr Speaker: Order. We did say, when we had the conversation, that there should just be an introduction to the debate very early on. I think this is why Members are beginning to get frustrated; we should now be speaking to the amendments.

Kim Leadbeater: Thank you, Mr Speaker. I will move on to the amendments. If I may, I want to acknowledge the work of the Bill Committee in relation to the amendments, because a huge amount of work was done by Members from all parties, with a range of views—

Mr Speaker: Order. I am really bothered, because today is a day for amendments, and we really need to understand the views they cover. As the Member in charge of the Bill, you will, I am sure, really want to get into the depth of the amendments and not continue in that way.

Kim Leadbeater: I do indeed, Mr Speaker; you are absolutely right. The amendments that we are discussing today build on some of the work of the Committee, and I think that is important. We took a lot of steps to strengthen the Bill in Committee, and I was pleased to work collaboratively with colleagues in that way.

As I come on to the amendments, which have been tabled in my name, let me say that the Government are, of course, neutral on the issue of assisted dying, but have always been clear that workability is essential if the Bill is to pass. I have worked closely with an outstanding team of civil servants from the Department of Health and Social Care and the Ministry of Justice, and it is with their technical advice on making the Bill workable and giving coherence to the statute book that I propose these amendments today.

Sir Julian Smith (Skipton and Ripon) (Con): Will the hon. Lady confirm that those civil servants are 100% comfortable with the impact of the Bill and that people with disability, mental health issues, neurodiversity and other medical conditions will not be coerced or under pressure because of this Bill?

9.45 am

Kim Leadbeater: I thank the right hon. Gentleman for that intervention. The civil servants are clearly neutral on the issue. They certainly have not expressed any opinions on the content of the Bill. They have merely provided the technical advice and expertise, and they have done so brilliantly in that regard.

New clause 10, amendment 52 and new schedule 1 are tabled in my name. As well as correcting the injustices in the legal situation, one key tenet of this Bill is choice for dying people, but it is also important that there is choice for doctors and other healthcare professionals and, indeed, anyone else. The Bill was always clear that:

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

but new clause 10 expands that protection. It broadens the people to whom it applies and the functions to which it relates. New schedule 1 makes provision for enforcement of this right

> "not to be subjected to any detriment"

in connection with the Bill.

Laurence Turner (Birmingham Northfield) (Lab): Does my hon. Friend accept that there may be a weakness in new schedule 1, in as far as it protects a person from actions taken by their employer? For example, it would not necessarily protect an agency worker who is contracted to perform a service, but the original medical body decides not to re-engage that person's services.

Kim Leadbeater: I refer my hon. Friend to my previous comments that the Bill and these clauses and schedules have been drafted with the highest level of legal expertise. It is not something I anticipate being a problem.

Sir Desmond Swayne (New Forest West) (Con): The Bill does allow applicants to shop around for doctors, and it strikes me that there is a danger that some doctors, who might have an ideological view of the Bill, will specialise in the provision of that service, which would give it rather greater scope than the hon. Lady intends.

Kim Leadbeater: I reject the assertion that patients will shop around. Bearing in mind that we are talking about dying people, they are not in a position to start shopping around for services, but I also agree that the Bill is strict in that regard. There are very strict protocols that doctors will have to follow.

David Mundell (Dumfriesshire, Clydesdale and Tweeddale) (Con): Will the hon. Lady give way?

Kim Leadbeater: I will just make some progress, if I may.

It is about not just patient choice but choice for professional people, too. We know there are a range of views on assisted dying across a range of professions. I have always been clear that no one who is uncomfortable taking part should have to, and nor should there be any detriment to anyone, whatever choice they make in whatever role they have.

Ms Polly Billington (East Thanet) (Lab): It is welcome that new clause 10 seeks to protect more individuals, but can my hon. Friend say why she has still not chosen to make provision for hospices and care homes to opt out without having their funding threatened?

Kim Leadbeater: There is absolutely nothing in the Bill that has any suggestion that any funding would be impacted by whatever decisions organisations make around assisted dying.

I will make some progress. New clause 10(1) states clearly:

> "No person is under any duty to participate in the provision of assistance in accordance with this Act."

That is something I feel strongly on a personal level. If people do not want to be involved, they should not have to be involved, and those who do, should. Subsection (5) covers pharmacists and pharmacy technicians and new schedule 1 provides comprehensive employment protections, so I hope that whatever colleagues' views are on assisted dying, they will see the value of these changes and support them.

Mr Toby Perkins (Chesterfield) (Lab): I thank my hon. Friend for these amendments, because a number of people have written to me concerned about the very issue that she is raising. Does she agree that many people will just be opposed to assisted dying in all its forms, and I entirely respect that, but if that is really their objection, they should be honest about that and not pretend that it is only particular amendments they need? They should make the argument that they actually want to make.

Kim Leadbeater: I thank my hon. Friend for that intervention, and I agree that we must be respectful, but we must also be honest with each other.

Amendment (a) to new clause 10 was tabled by the hon. Member for Reigate (Rebecca Paul), who I thank for her work on the Bill Committee. I understand the thinking behind the amendment, but I worry about

[Kim Leadbeater]

unintended consequences for patient care and protection. I have been advised that that is the case, and I think the Minister will speak to that. I think there is consensus across the House that, in the interests of patient safety, it is vital that there is clear and open communication, and sharing of information, between healthcare professionals in the assisted dying process. If an employer can stop their whole workforce participating in any sort of assisted dying services, it could prevent the sharing of information or the recording of information in a patient's records. That could relate to safeguarding, and it could put patients at risk as a result of the employer's decision. Terminally ill patients may be receiving different treatment at different places and from different healthcare professionals, and it would potentially be harmful if they were not able to transfer information or records.

There are also workability issues with amendment (a) to new clause 10. It is not clear how it would work with regard to the requirement in subsection (7) for professionals to provide information to an assessing doctor about a patient—someone whom they may have previously treated—or in relation to information about a specific condition that they may specialise in. That information would need to be provided in the interests of patient care. An employee will always be bound by their contract of employment, but flexibility is needed, as many health and care professionals work for multiple employers. It is not uncommon for clinical staff to have more than one employer—for example, a doctor may be employed by the NHS but also work for a hospice—so it is not a straightforward scenario. Just as it would be wrong for anyone to be compelled to be involved in the process, it would be wrong for anyone to be prevented from doing so, particularly if there was an impact on patient safety.

Peter Swallow (Bracknell) (Lab): Before Second Reading, I held a public meeting where I heard a range of views from my constituents. One thing that kept coming up was the need to protect medical professionals from being compelled to take part in assisted dying. I am really pleased to see that being addressed in new clause 10, but does my hon. Friend agree that having the choice to take part must go both ways for medical professionals?

Kim Leadbeater: My hon. Friend is absolutely right. We keep coming back to the word "choice". It is about choice for patients and terminally ill people, but it is also about choice for medical professionals and others.

Because of the unintended consequences, I cannot support amendment (a), but I am confident that new clause 10 and new schedule 1 provide robust protections for employees, regardless of their choices about participating in the provision of assisted dying services.

Lola McEvoy (Darlington) (Lab): Would my hon. Friend mind elaborating on the detail of the transferring of medical records? It is my understanding that someone can request their own medical records as a patient.

Kim Leadbeater: The patient could request information, but so could doctors and other healthcare professionals. It would be wrong if people were not allowed to share that information if it was requested, even if their employer did not want them to do it.

I turn now to new clause 11 and consequential amendments 64 and 65, which will ensure that the Bill is workable by making provision about the replacement of the co-ordinating doctor or the independent doctor where they are unable or unwilling to continue to carry out their functions in the Bill. The doctor may be ill or on holiday, retire, or have a change of personal circumstances.

Gregory Stafford (Farnham and Bordon) (Con): What concerns me about new clause 11 is that, essentially, people can shop around if one doctor is unwilling. The hon. Lady has given a list of reasons why a doctor might be unwilling, but surely one of the reasons could be that there is a fundamental change in a person's circumstances and they do not want to do it. Nothing about that is recorded. Is it not a real weakness of new clause 11 that we do not have the passing on of evidence from one doctor to another?

Kim Leadbeater: This is not about eligibility; it is about the doctor's change of circumstances, rather than the patient's. If the doctor decides that the person is not eligible, they will reject the application. They would record that in the patient's records, so it would be transparent.

Ms Billington: Will my hon. Friend give way?

Kim Leadbeater: I will make some progress, if I may.

This is essentially about providing flexibility for doctors while ensuring continuity of care for patients, and I hope colleagues can support new clause 11.

Dr Caroline Johnson (Sleaford and North Hykeham) (Con): Will the hon. Lady give way?

Kim Leadbeater: I will make a little more progress, if I may, because a lot of people want to speak.

New clause 12 ensures that there is thorough reporting of instances where the co-ordinating doctor concludes that the patient does not meet the strict eligibility criteria set out in the Bill. It is very important that this data is recorded, but at present there is no requirement for the co-ordinating doctor to produce a report when they are not satisfied about all matters set out in clause 23(5) and will not provide the person with the approved substance. That lack of a reporting obligation does not align with the rest of the Bill—hence new clause 12, which I am sure colleagues will feel it is important to support.

Ms Billington: I thank my hon. Friend very much for giving way. Although it is important that a doctor's reasons for refusing to provide assistance are noted down, there is nothing in the Bill to ensure that, if the person makes another request in the future, the next co-ordinating doctor will be made aware of the first doctor's report. Will she say something to reassure those of us with concerns that people suffering mental ill health, including depression, may seek assistance repeatedly until they find a doctor who will assess them as eligible?

Kim Leadbeater: That would not be an issue, because copies of the report would be given to the patent, the co-ordinating doctor if they are not in the patient's

GP's practice, and the commissioner, so that information would be recorded, and it is very important that it is. The report must set out the reasons—

Dr Caroline Johnson: Will the hon. Lady give way?

Kim Leadbeater: I will make some progress, if I may. I am trying to be very open to interventions, but I do need to crack on.

The report must set out why the co-ordinating doctor is not satisfied and must contain an explanation of why the patient cannot proceed with the assisted dying process. The co-ordinating doctor must give a copy of the report to the person, to the person's GP practice if they are not a practitioner within that practice, and to the voluntary assisted dying commissioner. That reflects the thorough and robust reporting and monitoring mechanisms throughout the Bill.

I turn to the other amendments in my name. I will try to keep my comments succinct, as many colleagues wish to speak. Amendment 56 ensures that the co-ordinating doctor gives the commissioner a copy of the patient's first declaration. That enables the commissioner to carry out their monitoring responsibilities under clause 45. Amendments 57 and 61—

Dr Caroline Johnson: Will the hon. Lady give way?

Kim Leadbeater: I will.

Dr Johnson: Persistence pays off. When considering the Bill, I had presumed that the doctor concerned would be a senior clinician—a senior doctor—but page 63 of the impact assessment refers to pre-registration doctors, who have just completed medical school and are on a provisional registration. Will the hon. Lady confirm that it is her intention that the provisions in the Bill may be carried out by the most junior doctors, as well as by more senior consultants and general practitioners?

Kim Leadbeater: I thank the hon. Lady for her intervention. Given her background, she knows what she is talking about. Regulations will set out the level of expertise required by the doctor, but there will also be training for every single doctor taking part in the assisted dying process. That is done well around the world, so there is work we can build on in that regard.

Amendments 57 and 61 are essentially tidying-up amendments that modify the wording of the Secretary of State's duty to set out training requirements in clauses 7 and 10. That fits with the intervention from the hon. Member for Sleaford and North Hykeham (Dr Johnson). Training is of paramount importance within the assisted dying process, and there will be a period of years in which anyone who opts in to be part of this process will have thorough and robust training.

Due to amendments made in Committee, with very good intention, the current wording suggests that the regulations themselves must include details about training. That obviously does not make sense and would be unworkable, as it would have to be done separately. Similarly, amendment 58 removes unclear drafting as a result of changes made in Committee that could have the effect that the regulations have to contain training about training, which obviously does not make sense.

Amendments 59, 52, 74 and 62 are also tidying-up amendments that are necessary as a result of the introduction of compulsory training for all doctors and panel members in domestic abuse and coercive control, following amendments tabled by my hon. Friend the Member for Lowestoft (Jess Asato), which the Bill Committee voted unanimously to accept.

Amendment 74 ensures that the term "domestic abuse" in the Bill has the same meaning as in the Domestic Abuse Act 2021. It clarifies the definition of "domestic abuse" and ensures that the term is consistent with existing legislation. It provides for a very broad definition to capture the full range of behaviours, including physical or sexual abuse, violent or threatening behaviour, controlling or coercive behaviour, economic abuse, and psychological, emotional or other abuse. It does not matter whether the behaviour consists of a single incident or a course of conduct. These really important amendments address concerns about coercion and provide additional layers of safeguarding within the Bill. As such, I hope colleagues support them.

Amendment 60 makes provision, corresponding to the provision in clause 12 about the death or illness of a doctor from whom a second opinion is sought, for a further referral to be made where, before reporting, the independent doctor dies through illness, or is unwilling or unable to act. The amendment once again ensures continuity of care and is an important detail to add to the Bill.

Amendments 67 and 68 clarify the provision of clause 23 in cases where an approved substance requires administration via a medical device. The current drafting of the clause is not clear about whether it is allowable to administer the approved substance via a device, which it is. The amendment provides clarity for clinicians.

10 am

Amendment 91 expands the duty on what must be included in the final statements of patients accessing assisted dying services. It includes additional information to be collected, including whether the person has a disability other than a disability consisting of the illness or disease which caused them to be terminally ill. Data collection and analysis is an important part of the robust monitoring and reporting built into the Bill.

Amendments 78 and 79 relate to the decisions of the multidisciplinary voluntary assisted dying panels, as set out in schedule 2—an important change made in Committee. Each panel comprises a legal expert, a social worker and a psychiatrist.

Dr Allison Gardner (Stoke-on-Trent South) (Lab): The Royal College of Psychiatrists states that it does not feel that, at this moment in time, there are sufficient psychiatrists able to take up a position on such a panel. What response does my hon. Friend have to that?

Kim Leadbeater: I thank my hon. Friend for that intervention. The Royal College of Psychiatrists has a neutral position on the issue of assisted dying. If we refer to the impact—*[Interruption.]* Yes, it does.

Shockat Adam (Leicester South) (Ind): Will the hon. Lady give way?

Kim Leadbeater: I will just finish this point. If we refer to the impact assessment, the number of people who will access assisted dying in the first few years will be very small. I think there are around 4,500 psychiatrists in the country, but there is also a period of time of a number of years to do the training required for psychiatrists taking part in the process, so I would not anticipate any problems there.

Jim Shannon: Will the hon. Lady give way?

Kim Leadbeater: I will keep going, if I may, because I think I have been fairly fair.

Amendment 78 ensures that all three members of the panel must agree before a certificate of eligibility is issued, so abstentions cannot result in approval. The amendment came about as a result of discussions in Committee. It is really important to clarify that when the panel of experts is doing its work, its decision must be unanimous for a certificate of eligibility to be granted and for the patient to proceed. If a panel member abstains, no certificate of eligibility can be granted to the person.

Schedule 2 also sets out that the panel must give reasons for its decision in each case. This is really important. Amendment 79 ensures that those reasons—the reasons for the panel's decision—are communicated in writing in a document to the person to whom the referral in question relates, the co-ordinating doctor and the commissioner. This creates clear channels of communication and will enable those people to fully understand the expert panel's decisions.

Jim Shannon: Will the hon. Lady give way on that point?

Kim Leadbeater: I am going to finish, if I may, because other people want to speak.

Amendment 14, which was tabled by my hon. Friend the Member for Bradford West (Naz Shah)—another outstanding member of the Committee—states:

> "A person who would not otherwise meet the requirements of subsection (1) shall not be considered to meet those requirements solely as a result of voluntarily stopping eating or drinking."

I suspect the amendment has been put forward as a result of the lengthy discussions in Committee regarding whether people with anorexia would be eligible for an assisted death under the Bill. In my previous career before becoming an MP, I worked with a number of people with eating disorders. I am very aware of the hugely sensitive and complex issues surrounding disordered eating, particularly anorexia. I also know that this is a personal issue for a number of colleagues across the House, as a result of their own experiences. Eating disorders cause huge distress for individuals, their families and loved ones, but with care and the right treatment, it is possible for people to recover and to go back to leading a full and fulfilling life.

Simon Hoare (North Dorset) (Con): The hon. Lady is absolutely right on the matter of eating disorders, but my understanding of the amendment is that it relates to those who effectively starve themselves into a position of becoming terminally ill without having an eating disorder—that is the thrust of the amendment. Does she see that, and how does she intend to respond to it?

Kim Leadbeater: The hon. Gentleman makes an important point. The amendment is not specifically about eating disorders; there is a broader context. I will come to that later.

It is with that experience in mind—my own personal experience and having spoken to many colleagues on this issue—that I say now, as I said in Committee, that under the Bill as it stands, having anorexia would not qualify a person to be eligible for an assisted death. The Bill is clear that a person cannot be considered terminally ill on the basis only of a mental disorder. Clause 2 makes it clear that a person must have an inevitably progressive illness or disease that cannot be reversed by treatment. Anorexia is a serious mental health condition that is not inevitably progressive and can, thankfully, be reversed by treatment. Of course, at every stage of the assisted dying process the patient must be found to have capacity to make the decision, and this is checked repeatedly throughout the process. Someone with severe anorexia would be highly unlikely to be assessed to have capacity to make a decision on assisted dying.

The other tragic reality is that if a patient was so ill as a result of not eating and drinking for whatever reason, they would die before the process of assisted dying was able to take place, as it could take up to two months to complete all the stages of the process as set out in the Bill, and the latest clinical guidance states that the general range of survival once voluntary stopping of eating and drinking has begun is between seven and 21 days. Stopping eating and drinking also leads to a range of symptoms that would make meaningful conversations, as required by the Bill, impossible.

Having said that, I know that some people have expressed concerns that the severe physical consequences of a decision to stop eating or drinking could still enable someone to claim eligibility for assisted dying when they would not otherwise be able to do so, and I believe that is the motivation behind amendment 14.

Jim Shannon *rose—*

Kim Leadbeater: I will take one final intervention.

Jim Shannon: The hon. Lady is very kind. At the moment, she is outlining the case for those who have problems with their eating and their diets almost to the point where they are unable to make their own decisions, and she is outlining what is going to happen here. What would she say about the situation in Belgium and in Canada, where assisted dying has been legalised for people with eating disorders? This may progress from what she has said and go way beyond that, as has been proven in other countries across the world.

Kim Leadbeater: I thank the hon. Gentleman for that point. The eligibility criteria in this Bill are very different from those in the jurisdictions he mentions—people with mental health conditions are not eligible for assisted dying under the provisions of this Bill.

Patricia Ferguson (Glasgow West) (Lab): Will my hon. Friend give way?

Kim Leadbeater: I will just finish this point, because it is very important.

I acknowledge the concerns that colleagues have expressed around this issue, and I believe they are the motivation behind amendment 14. As I have set out, I think that risk is negligible. I have taken advice, and there is some concern that clinicians might have difficulty assessing with certainty that the decision to stop eating and eating was the only reason for a person's terminal prognosis; as such, some further drafting changes may be required in the other place if this amendment should pass. With that in mind, however, and to ensure there is no sort of loophole, no matter how small the reality is of there being one, I am happy to support this amendment today.

Several hon. Members *rose—*

Kim Leadbeater: I am going to leave it there for now, if I may.

I am conscious that many colleagues wish to speak in this important debate, and I am keen to hear their contributions, so I will conclude my remarks there. I thank colleagues for listening, and I hope they are able to support the amendments in my name today in the interests of strengthening the workability of the Bill and providing greater flexibility and safeguards for patients and professionals.

Rebecca Paul (Reigate) (Con): It is a privilege to speak in this place on such an important Bill. Having been part of the Committee that scrutinised it line by line, and, on some occasions, word by word, for several months earlier this year, it is a pleasure to see so many of my colleagues from Committee Room 10 present today—a reunion of sorts. I am here, as always, with the intention of improving the Bill, so that if it does indeed pass, vulnerable people are as protected as they can possibly be from unintended consequences.

It is important to remember that on Report and Third Reading we are not voting on whether we agree with the principle of assisting someone to end their own life. Our role is to vote on the law in front of us—on whether the words on the page are clear and do what is intended, on whether the statutory process is safe, and ultimately on whether the provision of assisted dying benefits our community.

I am not against assisted dying in principle, but I am against this Bill. I am happy to put it on the record now that I have no personal religious beliefs; I am against the Bill for the simple reason that it will harm far more people than it will help. The people who will be harmed are the most vulnerable in our communities, and I am not willing to accept that collateral damage.

Today is important, because we have the opportunity to improve the safeguards in the Bill so that some of those groups are better protected. I urge Members to take that opportunity to the full. It requires very little skill to draft law that works for 90% of cases, but there is much skill in ensuring that the other 10% is catered for as well. I urge everyone to set the highest standards today and think about how we can ensure that those unordinary and unexpected cases are adequately protected, too. It really is life and death, so please do not accept anything that is not good enough.

Iqbal Mohamed (Dewsbury and Batley) (Ind): Does the hon. Member agree that one of the greatest risks in this Bill is around coercion? It is not just about coercion from family members or friends, but about societal coercion and circumstances. The current state of palliative care in our country is among the worst in the developed world. Without adequate palliative care, patients might feel pressure to go down the assisted dying route instead.

Rebecca Paul: I wholeheartedly agree.

There is much to discuss today and there is little time, so I will start at the beginning of the Bill, at the point at which the criteria for eligibility for an assisted death are set. It is there that important safeguards are needed to ensure that those who should never be eligible are excluded. We should not make the mistake of assuming that a doctor will always make the right decision or that they are infallible. It is incumbent on us to put in place law that makes it harder for them to get it wrong—that makes it harder for someone vulnerable to fall between the cracks.

Mr Perkins: The hon. Lady has just agreed with a point made by the hon. Member for Dewsbury and Batley (Iqbal Mohamed). Exactly the same point was made when this House voted against the Assisted Dying (No. 2) Bill back in 2015. Would she say that in the nine years after the House voted against the Bill, we saw a golden age in palliative care as a result, or does she think that if we wait for palliative care to be perfect we might never vote in favour of assisted dying?

Rebecca Paul: The evidence is clear that palliative care does not get better when assisted dying is introduced; we heard that in the Bill Committee. We should absolutely look to address palliative care, because that will benefit more people. I will come to that point later in my speech, so I will not discuss it any further now. I do not want to get ahead of myself.

There are many helpful amendments in this vein—namely, new clause 16, new clause 9 and amendments 80, 14, 38, 81, 24, 30 and 31. In simple terms, they seek to tighten and refine the eligibility criteria for an assisted death by setting out when and for what reasons an assisted death should be allowed, and by ensuring that those who are vulnerable are protected from something that may not be in their best interests.

Interestingly, on Second Reading the argument put forward for assisted death was that those who are dying should be spared unbearable pain. This is an argument that everyone understands and has full sympathy with. No one in this place wants people to endure pain as they come to the end of their life; I certainly would not want that for my loved ones or indeed for myself when my time comes.

But then the arguments being put forward changed. There was less emphasis on pain, and more on choice and autonomy. The word "autonomy" came up again and again in Committee—and autonomy is important, of course, but up to a point. From a proposal to provide a humane end to someone's pain when it cannot be relieved in the last months of their life, we have moved to a proposal to provide an assisted death service to those who choose it for any reason, even if the pain can be alleviated by palliative care. This approach, however, comes with a cost to others: family, clinicians and broader society. This really is momentous. There is no going back from such a massive shift. A move to autonomy trumping everything else changes everything.

Sir John Hayes (South Holland and The Deepings) (Con): That is why new clause 16, tabled by my hon. Friend, is so important. In other jurisdictions that have passed such laws, up to a third of people report that they have taken this step because they feel they are a burden on others. That is the truth of it—it is not always about pain—and that is the kind of autonomy that leads to disaster.

10.15 am

Rebecca Paul: I thank my right hon. Friend for making that point; he is absolutely right.

I have tabled amendment 80, which would bring the Bill back to its original intentions. It would require that in order to be eligible for an assisted death, the pain and discomfort experienced or expected from a person's terminal illness could not be reasonably relieved to their satisfaction through palliative care. It seeks to limit assisted death to the very small group of people who may benefit from it, not the larger group who just need adequate palliative care to give them the comfortable, dignified death they deserve.

Dr Jeevun Sandher (Loughborough) (Lab): The hon. Member's amendment speaks of "severe pain and discomfort", but there is a reason why the medical profession has not gone for that. How does she propose we assess severe pain and discomfort as opposed to medium pain? Is a fungating wound part of severe pain and discomfort?

Rebecca Paul: The key point is that we need to improve palliative care. We are spending so much time and effort focusing on this Bill rather than doing the thing that would actually help more people. My amendment 80, in combination with amendments 30 and 31 tabled by my hon. Friend the Member for Runnymede and Weybridge (Dr Spencer), would drive significant improvements to palliative and end-of-life care, getting us closer to consistent and universally available care for all.

Anna Dixon (Shipley) (Lab): I support the hon. Lady's amendment. As the Royal College of Psychiatrists pointed out, pain from unresolved physical symptoms and the fear of physical pain or death can make a person want to die, and depression, which is also associated with a wish to die, is often missed. Does she agree that it is vital that people are supported to be free from pain by having access to good palliative and end-of-life care, and that the Bill's provisions should be available only to those whom that cannot help?

Rebecca Paul: I completely concur.

Jim Shannon: I commend the hon. Lady for tabling her amendments. Amendments that would have protected palliative care and hospices from facilitating assisted suicide services on their premises for ethical or practical reasons have been rejected, so the Bill leaves hospices with little choice but to comply. It also puts them in a difficult position when it comes to funding. Hospices will also have to provide a staff member to do this work. The problems that will create for palliative care and hospices cannot be ignored. The Bill goes against that right in its totality.

Rebecca Paul: I agree, and I will come to that point in more detail in the second half of my speech.

Dr Neil Hudson (Epping Forest) (Con): With regard to these amendments, we are so blessed to have our precious NHS. At vital stages, the NHS quite rightly delivers care in obstetrics, gynaecology, neonatology and paediatrics, but at the end of life about 70% of care is delivered outside the NHS, largely by charities, and that figure is even higher for children's palliative and hospice care—so the state pays for how we enter this life, but not for how we depart it. There is something deeply wrong about that for our society. Does my hon. Friend agree that surely we must address that, and the delivery of universal palliative and hospice care, before we go anywhere near the measures in this assisted dying Bill?

Rebecca Paul: My hon. Friend makes a good point, and I agree. In the interests of time, I will make some progress.

The current situation, whereby fully funded palliative and end-of-life care is not available in certain postcodes, means that those unfortunate patients do not have a real choice. We know that 25% of people who die in this country do not get the palliative care they need—that is more than 100,000 people a year—and if the Bill goes through, they will be offered a fully funded assisted death as the only reliable way to end their pain. That is no choice. I urge Members who want to see improvements in palliative and end-of-life care to vote for my amendment 80, and for amendments 30 and 31, tabled by my hon. Friend the Member for Runnymede and Weybridge, if they are pushed to a vote.

Dr Johnson: Will my hon. Friend give way?

Rebecca Paul: I will not because I do not have much time.

I will move on to the lack of a best interests test in the Bill, which my new clause 16 seeks to remedy. Patient autonomy is of course important, but it must be balanced against what is in someone's best interests. In certain situations, when it is in their best interests, treatment can be given against a patient's will—for example, force-feeding a young girl with anorexia. It is not an easy balance to get right, but in the absence of any best interests test in the Bill, following the process rigidly would lead to devastating results in some cases.

The Bill currently prioritises autonomy of the patient in a specific moment of time, rather than what might be in their best interests in the long run. It makes no allowance for the fact that someone may feel a certain way temporarily due to other considerations. For example, when someone has just received a terminal diagnosis, it can understandably cause a depressive state and suicidal feelings, but those feelings do not necessarily last, so it may be in the best interests of the patient to allow a little time to pass, to give them a little breathing space before considering the assisted death route.

New clause 16 essentially tries to provide a best interests test by excluding certain reasons, other than the alleviation of pain, that might be driving a patient's decision. For example, we have heard a great deal about the internal pressure from patients themselves that is driven by their concern not to be a burden, and we heard clearly in Committee that a patient could tell a doctor that they are want an assisted death only for financial reasons, and that would still be approved. We know from the experience of overseas territories that patients will often opt for an assisted death because of social and welfare issues, such as being homeless.

Paula Barker (Liverpool Wavertree) (Lab): Will the hon. Lady give way?

Rebecca Paul: I am sorry, but I do not have much time and I wish to get through my points.

How can we be happy with a process that does not exclude such reasons? Instead of providing the support that is actually needed, the state is content to put them on a pathway that leads to their death. I hope that the House will recognise that, whether one supports assisted dying in principle or not, it is morally bankrupt not to have some kind of best interests test to protect those who are not seeking death to alleviate pain from a terminal illness.

Another group that is particularly vulnerable is those with eating disorders. In Chelsea Roff's oral evidence, she set out that

> "at least 60 people around the world have been euthanised or assisted in suicide"

with

> "anorexia nervosa listed by name as a terminal condition."—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee,* 29 January 2025; c. 139, Q175.]

To paraphrase her, these were young women who were not terminally ill and had decades of life ahead of them. It is important to make the point that someone suffering—

Christine Jardine (Edinburgh West) (LD) *rose*—

Ellie Chowns (North Herefordshire) (Green) *rose*—

Rebecca Paul: I would love to give way, but—

Mr Speaker: Order. The hon. Lady has said that she is not going to give way. We are aiming for 15 minutes for each speech, but it is going to be 20 minutes if we do not pick up the pace.

Rebecca Paul: I apologise, but I do want to get through my speech.

It is important to make the point that someone suffering with anorexia, or indeed any mental condition, is not intended to be eligible for an assisted death. However, in the case of anorexia there are physical manifestations of the illness, such as malnutrition and diabetes, that might mean the patient meets the definition of being terminally ill, and that is the nub of the problem: the Bill does not adequately rule out physical manifestations caused by mental illness. That is why amendment 14, tabled by the hon. Member for Bradford West (Naz Shah), is so important, because it would ensure that anyone who voluntarily stops eating or drinking is ineligible for assisted dying. I support the amendment strongly as it addresses a big risk.

Lastly, on eligibility specifically, I want to talk about capacity. There are such problems with the current approach to determining capacity that I barely know where to start. When it comes to ending one's own life, a higher standard should be applied. The current definition of capacity was not created with such a monumental decision in mind, and if it were being drafted from scratch today, it would look very different. That is one of the reasons why the Royal College of Psychiatrists does not support the Bill.

Under the Bill, a person is assumed to have capacity in the first instance. A clinician only needs to be over 50% sure that a person has capacity. If the person is making unwise decisions, that is not taken into account, and a person can be "helped" to make a decision—for example, when a patient has learning disabilities. I ask all Members today whether they are happy with that. Does that sound like a robust approach to assessing whether someone has capacity to make the decision to end their own life?

Let us begin with the starting presumption of capacity. That, too, lacks the standard for assisted death decisions. I therefore support amendment 24, tabled by the hon. Member for Bexleyheath and Crayford (Daniel Francis), which would disapply section 1(2) of the Mental Capacity Act 2005 for the purposes of assisted dying. One of the biggest issues for me is the fact that the current approach requires an impairment or disturbance of the brain in order for someone to be considered not to have capacity, irrespective of whether they can make a decision. In the real world, that would mean a doctor could assess a patient who gives the impression of being confused, illogical, erratic, inconsistent—everything about them could scream that they are not in a good place to make this decision at that point in time—but they would still be considered to have capacity if there is no identifiable impairment or disturbance of their mind or brain. That could potentially put those with depression, anxiety, learning disabilities or eating disorders, or even those just experiencing physical pain that is driving them to distraction, in danger of being considered to have capacity when they do not.

So far I have focused on eligibility. I will now talk about hospices.

Mr Speaker: Order. Please, I really want to get as many people in as possible. If you can come to a conclusion, that would be helpful.

Rebecca Paul: I will therefore speak to my new clauses 17 and 18, which would provide important protections for hospices, which are currently lacking in the Bill. New clause 18 makes it crystal clear that any regulated care home or hospice can decide whether to provide assisted dying on its premises, and new clause 17 makes it clear that they cannot be subject to any detriment for not providing or permitting assisted deaths, and that their public funding cannot be conditional on their providing this service. Whether one is in favour of assisted dying or not, we must preserve the rights of organisations, companies and charities to choose whether to offer it. They must never be forced into it by public funding being conditional on the provision of assisted dying.

I note that new clause 10, tabled by the hon. Member for Spen Valley (Kim Leadbeater), would expand the protection for individuals not to participate in the assisted dying process if they so wish. It seeks to protect employees from being subjected to any detriment for participating or not participating in the provision of assisted dying. This sensible protection would ensure that if an NHS hospital provides an assisted death service, any member of staff who does not want to participate would not have to do so and would suffer no detriment as a result. However, there needs to be a sensible mechanism balancing that against the employer's right to set their own policy on assisted dying, and that is what my amendment (a) to new clause 10 seeks to do—we have already talked about that, so I will not go over it again.

I did want to talk about process and family, but it looks like I will not have time to do that. I will end there. I thank you for your patience and generosity, Mr Speaker. I am grateful that I have had the chance to speak in support of the amendments, and I look forward to hearing from other Members.

Dame Meg Hillier (Hackney South and Shoreditch) (Lab/Co-op): I rise to speak to new clauses 1 and 2, which stand in my name, and consequential amendment 2, and I will touch on others at the end. These amendments—without being dismissive of those who helped me draft them—are imperfect. Those of us who are not the promoter of the Bill have not had the support of Government drafters in tidying up the Bill. We need to acknowledge that the Bill in front of us today is the Bill—more or less—that will or will not be passed by this House. For any amendments made, by the point of Third Reading, that is it—there will be no further opportunity to redraft them.

Sadly, one of these amendments was rejected in Committee. If those changes had been discussed before the original Bill was published, or even in evidence before Committee, we would have been in a better place to get that tighter drafting that is needed in making good legislation. We are not a debating society; we are now legislating for a law that would enable the state to assist in people taking their lives. I am sad that we are able to discuss these amendments only now. I did not get the opportunity to be on the Bill Committee, but I commend all Members who spend so many hours discussing and debating those issues.

The ramifications of the clauses I want to talk about are important for potential users of a service, for medical professionals, for families and for other health professionals. The Bill currently allows doctors to suggest assisted dying to a patient who has not raised it themselves. This, I believe—as I know many others do—presents a serious risk that terminally ill patients, already highly vulnerable, will feel pressured to end their lives.

Dr Simon Opher (Stroud) (Lab): I realise that my hon. Friend's new clause 1 comes from a good place, but can she not see that it is inconsistent with our ethical obligations as doctors? That is why the British Medical Association has suggested that although there should be no duty to raise the issue, neither should there be a ban on doing so. I ask her to consider that the Australian state of Victoria initially had such a measure—a so-called gagging clause—as part of its Bill, but it was removed because it caused confusion and was detrimental to patient care. Should we not learn from that?

10.30 am

Dame Meg Hillier: I thank my hon. Friend for his point, which brings me to something I really want to address. As I said in my opening remarks, these are imperfect amendments. I will get into some of the conversations that I have had with a number of people about this. I am one person; I have not been able to consult the BMA, as a Government or a sponsor could, for example, but I am aware of its concerns. However, we are talking here about very definite and irreversible decisions on life and death. I know that many doctors have had conversations about that, but not to the level required to legislate for it. This is a different set of circumstances, but I very much appreciate his point.

Ms Diane Abbott (Hackney North and Stoke Newington) (Lab): Does my hon. Friend agree that far too many people do not have confidence in the face of authority, and that if a doctor raises assisted suicide with them—no matter how tactfully or professionally—they will feel that they are being steered in that direction?

Dame Meg Hillier: I thank my right hon. Friend for that intervention. Given her many years as a constituency MP in the same borough as me, we both know many such vulnerable people. Dr Rachel Clarke, a hospital palliative care doctor, said:

> 'If, for instance, you say to a vulnerable patient who has just been told they have a diagnosis of terminal cancer, "Have you thought about assisted dying?", I would suggest that stating it broadly like that is a form of pressure and that you are potentially unintentionally coercing that patient.'—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee,* 28 January 2025; c. 75, Q93.]

So we are in a very difficult space, as my hon. Friend the Member for Stroud (Dr Opher) highlighted, with his background as a practising GP. We recognise that. As I have said, this is an imperfect process to deal with that challenge, but it is a very different set of circumstances compared with the other advice that doctors give.

Dr Johnson *rose—*

Dame Meg Hillier: Speaking of doctors, I give way to the hon. Lady.

Dr Johnson: I rise to support the hon. Lady's new clause 1. As a doctor, I am very aware of the trust that the public place in doctors and the seriousness with which they take what we say. If a doctor gives somebody information about assisted dying, it is quite reasonable for that person to think that the doctor is suggesting that they should take part in that process, or is hinting that their death will be dreadful and trying to be kind. If doctors are allowed to say, "This is a good process," more people will take it up than would otherwise have wanted to.

Dame Meg Hillier: I thank the hon. Lady.

Christine Jardine: Will the hon. Lady give way?

Dame Meg Hillier: I need to get into the arguments for my two new clauses, so I will not take any more interventions for the time being.

I believe that there is a serious risk that terminally ill patients, who are already vulnerable, could feel pressured into ending their lives sooner than they would wish to. We know of examples of patients who felt suicidal and low at the point of diagnosis, and at that point they are vulnerable—this is not the debate in which to make points about that—but often, with good care and pain relief, they can move away from that decision. There is also the issue about the burden on family.

Christine Jardine: Will the hon. Lady give way?

Dame Meg Hillier: I must make progress.

I also want to talk about how the teenage brain works. The Bill would apply to a young person at the age of 18. A month or so after they reach that age, they could undertake an assisted death. Let me highlight some of the good conversations that I have had with people who have generously given their time to speak with me about these important issues, which I am worried have not been addressed at any point in the Bill's passage, except for a short and important discussion in Committee.

Catherine Fookes (Monmouthshire) (Lab): Will my hon. Friend give way?

Dame Meg Hillier: Let me finish my point about doctors' advice before I move on to the issue of 18-year-olds. Dr Alexandra Mullock, who is a senior lecturer in medical law and co-director of the centre for social ethics and policy at the University of Manchester, said in written evidence to the Bill Committee:

> "The freedom for a registered medical practitioner (RMP) to raise/discuss the option of seeking help to die in clause 4(2) is ethically problematic."

She also highlighted:

> "Professional advice regarding treatment will be received by the patient as a recommendation",

as the hon. Member for Sleaford and North Hykeham (Dr Johnson) said. That is a really big concern. The UK coalition for deaf and disabled people is very concerned, and would like this provision removed as well.

Tim Farron (Westmorland and Lonsdale) (LD): The hon. Lady makes an excellent point. Does she also acknowledge that, given what we are beginning to know about coercive control, the suggestion by a doctor—innocently; maybe neutrally—that this is an option could be latched on to by someone who is coercively controlling the person who may choose assisted dying, and we would never find out that that had been the case until after the person's death, if at all?

Dame Meg Hillier: The hon. Gentleman highlights an important point in relation to my amendment and others: in this House, we made coercive control illegal in legislation only in recent years. This is such a big issue, and what is different about the Bill—this is why some positions are particularly challenging—is that we are talking about irreversible decisions.

I want to talk a bit about how the teenage brain works. Children and young people are particularly susceptible to being influenced, including into dangerous and risky behaviour. In a number of countries, assisted dying laws have been expanded to allow children and young people to end their lives. We need to be alert to that very real risk. I am impressed by the work of the Children's Commissioner, who recently published a report into children's views on assisted dying. It was heart wrenching to read. Those with illnesses and disabilities were particularly concerned about what the Bill means for them. These children have not really had a voice in the debate so far, and there is talk about whether the Bill may apply to children with life limiting or severe progressive diseases.

Sorcha Eastwood (Lagan Valley) (Alliance): I, too, am greatly concerned about our young people. I was at an event in my constituency of Lagan Valley the other night, at which it was said that almost all our young people across the UK are having their mental health impacted by social media. If we throw this into the mix, it has the potential to do untold damage. I do not support the Bill, but I applaud everybody who has taken the time today, regardless of their view, to try to make it better. However, I have grave concerns about its ramifications.

Dame Meg Hillier: I thank the hon. Lady for her comments. If I have time, I will touch on social media, but I want to put on the record my thanks to some of the professionals who gave of their time to speak to me in preparation for my amendment.

Catherine Fookes: Will my hon. Friend give way?

Dame Meg Hillier: Not at the moment.

I had some very interesting conversations with Sophie Scott, professor of cognitive neuroscience at University College London; Sallie Baxendale, professor of clinical neuropsychology at UCL; Sarah-Jayne Blakemore, professor of psychology and cognitive neuroscience at the University of Cambridge; Dr Richard Hain, consultant and clinical lead, all-Wales managed clinical network in paediatric palliative medicine at Cardiff and Vale university health board; and Dr Anna-Karenia Anderson, consultant in paediatric palliative medicine and medical director for Shooting Star children's hospice. I am only sad that there has not been a bigger debate, because the process has not allowed for one. I apologise to them in advance that I will not be able to do justice in the time that I have to the very many careful and thoughtful points that they raised.

Catherine Fookes: Will my hon. Friend give way?

Dame Meg Hillier: I have said no—I need to explain the issues, and give due credit to the people who have assisted me in raising them.

Adolescents' brains develop differently. From the age of puberty, there is a rapid change in how young people make decisions. As adults, we have the experience to imagine what the future might look like, but younger people, up to about the age of 25, often cannot plan or predict their future because that part of the brain has not developed well, and they are not good at understanding regret. The comparisons are different for adults. Role models and social groups matter a great deal.

Christine Jardine: I appreciate the hon. Lady giving way, given the time constraints. Does she acknowledge the concern that many of us have about not telling patients all the options, particularly young people who are now so social-media literate? Their automatic reaction is to Google everything; in fact, we all do it. The danger is that, if they are not told all the options and given the guidance that is available, they will go to Google and see yet more of the dangerous suicide attempts that we see at the moment.

Dame Meg Hillier: I do not have time to completely unpick the hon. Lady's points, but to have something positively suggested is a big issue for young people, so the social media aspect is important.

The social network matters. At the point of puberty, teenagers will look to their social group, which will massively influence their behaviour in a way that their families will not. Adolescents are more likely to take risks: their neurodevelopmental underpinnings are different, and pathways between the rational and the emotional parts of the brain are not fully developed. In "a hot situation", where there is a lot of emotion, they take more risks, particularly because they do not have the ability to think about the counterfactual. In this case, the counterfactual is not being here anymore; that is a very difficult thing for a lot people to understand, particularly young people.

The ability of young people to think flexibly and change their minds is in the front of the brain, which does not always react to the—

Ellie Chowns: On that point, will the hon. Lady give way?

Dame Meg Hillier: I need to make some progress. Madam Deputy Speaker, I am trying to speak at great pace.

Teenagers are passionate about their beliefs and peers can change their minds in a way that their parents often cannot. There is not always a logical decision-making path. A doctor would carry weight. In response to the point made by the hon. Member for Edinburgh West (Christine Jardine), a child may be thinking about dying but somebody—that doctor or professional—could make their decision a legitimate option.

There are many issues in palliative care. We talked about Gillick competency, but to be clear, young people under the age of 18 can make their own decisions about healthcare. Even young people under the age of 16 can have such conversations because of Gillick competency, which is a good principle, but the issues around mental capacity and Gillick competency are often not well put in place—

Catherine Fookes: On that point, will my hon. Friend give way?

Dame Meg Hillier: I have said no to my hon. Friend—I have moved on from the points that she wanted to talk about.

The law is ambiguous about Gillick competency. The Mental Capacity Act 2005 and Gillick competency triangulates through the person but also the condition, so it relates to the complexity of the condition as well as to the individual. Peer pressure is a big part of what has an impact on people, as well as the view of the professional or doctor.

Daisy Cooper (St Albans) (LD): On that point, will the hon. Lady give way?

Dame Meg Hillier: I need to make progress.

On the issue of children making a decision at the age of 18, they could have a conversation with someone about dying and then on their 18th birthday sign on the dotted line; the conversation would not even have to be at that point. We need to understand that even at the age of 18 or 19, young people's brains are in a different place on this. If we pass the Bill, we are saying that at the age of 18, 19 or 20, people could have an assisted death. We need to understand the ramification of that for those people.

I want to ensure that I cover some of the other points that hon. Members have made. I do not have time to go through all the amendments that play into this, but strengthening the panel and the safeguards, as well as the issues that hon. Members have raised around coercion and capacity, are very important. There has not, however, been time to work through how those issues have an impact on younger people. If only I had time to go into some of the evidence I have received—I have only been able to give a hasty run-through because of the pressure on time today, which is a sign of the challenges of the process. We have not got time to go into the detail that we need to consider.

Socialisation is important. Social media has a very big impact and we need to understand that that will have an impact on young people making their decisions.

Several hon. Members *rose*—

Dame Meg Hillier: I am trying to do the maths on my timing. I fear I have run out of time. I would like to speak for longer, but I sense from the mood of the House, and from you, Madam Deputy Speaker, that hon. Members do not wish me to do that. I am very concerned that the issues have not been properly discussed. I again remind hon. Members that if we vote on the Bill, these matters have not been fully tested with the professions concerned, as we have heard from the Royal College of Psychiatrists this week and from many of the other professions who would have to grapple with the legislation in practical terms. What we are doing now is legislating for the real practice of delivering those measures, and we have not had time to fully explore that.

Several hon. Members *rose*—

Madam Deputy Speaker (Judith Cummins): I remind Members that we currently have a 15-minute guide limit for speeches, so please help each other so that as many Members as possible can speak.

10.45 am

Dr Neil Shastri-Hurst (Solihull West and Shirley) (Con): This House is now faced with a responsibility as profound as it is complex: to ensure that this Bill remains clear in its purpose, cautious in its application and compassionate in its impact. That purpose is simple, yet solemn: to grant adults of sound mind with a terminal diagnosis the legal right to seek assistance to end their lives in carefully regulated circumstances through a legal framework in which compassion and control co-exist. With that in mind, I rise to speak against new clauses 1, 2 and 9, which, while no doubt well intentioned, threaten to confuse, dilute or duplicate what is already a well-constructed piece of legislation.

I begin with new clauses 1 and 2. New clause 1 would prohibit healthcare professionals from raising the topic of assisted dying unless it is first broached by the patient. While that may be appealing superficially as a safeguard, it represents a fundamental misunderstanding of the doctor-patient relationship. We trust our clinicians every day to raise subjects of great complexity and moral weight.

Florence Eshalomi (Vauxhall and Camberwell Green) (Lab/Co-op): Does the hon. Member agree that, unfortunately, some of our constituents up and down the country do not trust our clinicians? They have grave concerns about the way in which they are treated, because they feel that they do not have a level of equality within our NHS, which is sadly the case. That was explained and shown during covid.

Dr Shastri-Hurst: I am grateful to the hon. Member for that intervention. I fear there is some rhetoric that engenders a fear around the medical profession, which is misplaced.

Daniel Francis (Bexleyheath and Crayford) (Lab): Will the hon. Gentleman give way?

Dr Shastri-Hurst: I will give way in a moment, if I may.

Those are not my experiences in clinical practice, nor are they those of family members who have worked in it. We must trust our medical professionals, who are highly trained and capable individuals, to have these difficult and complex conversations, which they do every day on issues such as aggressive chemotherapy or the withdrawal of ventilation.

Daniel Francis: The hon. Gentleman, like me, sat on the Bill Committee. He heard, as I did, that if somebody had a learning disability, they were five times more likely to have a "do not resuscitate" order placed on them during the pandemic. Did he hear that evidence? Why does he not agree with it?

Dr Shastri-Hurst: I am grateful to the hon. Gentleman for his intervention. These are complex conversations that take place up and down the country every day; we know that they are taking place in St Thomas' hospital at this moment. We are treating our medical professionals as though they do not take their professional obligations seriously. We must recognise the expertise that they bring and the sensitivities in which they have these conversations.

Melanie Ward (Cowdenbeath and Kirkcaldy) (Lab): I wonder if the hon. Gentleman has the experience, as I and the relatives of many disabled people up and down this country have, of having to fight the medical profession to get the attention and the worth that a loved one deserves when the medical profession is not listening to us or to what that loved one needs. That is the experience of many people up and down this country.

Dr Shastri-Hurst: I am grateful to the hon. Lady for her intervention. I commend those family members who are really powerful advocates for their children, parents and relatives in their engagement with the medical profession. We are at real danger of treating our clinicians as though they have no care for their patients—

David Smith (North Northumberland) (Lab): I am sure that all of us in this place respect and value our medical professionals. The simple point to make is that not everyone who goes before the medical profession has the same experience or confidence as some of us in this place.

Dr Shastri-Hurst: I am grateful to the hon. Gentleman for his intervention. That is why it is so important that we have the rigorous training and safeguards that are a fundamental part of this Bill.

Several hon. Members *rose*—

Dr Shastri-Hurst: I will make some progress, if I may. The point is that people cannot have a fully informed discussion and weigh up the balance of the decision if they do not know the full options available to them. That is a part of informed consent.

Shockat Adam: Will the hon. Member give way?

Dr Shastri-Hurst: I will make a little progress, if I may.

In respect of new clause 2, those who have had the privilege of meeting a young person living with a terminal illness will know that they often display a maturity and a depth of understanding far beyond their years. To deny them the opportunity of a considered conversation about their future upon reaching adulthood is not an act of compassion, in my view; it is to abandon them. It is to leave them isolated, navigating a complex and deeply personal journey through the filter of online forums, rather than in dialogue with trusted, qualified professionals. We owe them better than that.

Catherine Fookes: My constituent Noah was diagnosed at 16 with an inoperable brain tumour, and he has said he would like the right to choose:

> "The thought of being locked in unable to communicate is not how I want to spend the last months of my life. To end my life on my terms when the time comes would give me comfort."

Noah does not want to be infantilised; he wants to be treated like the adult that he is. Does the hon. Gentleman not agree that the Bill will give him that protection?

Dr Shastri-Hurst: I am grateful to the hon. Lady for her intervention. That is a very powerful personal story from Noah, who I think reflects the maturity of many young people when dealing with these challenging issues.

By imposing, in effect, a statutory gag in this one area, new clauses 1 and 2 risk infantilising terminally ill patients, creating a chilling effect on communication at the very moment when clarity and compassion are most needed. If anything, new clauses 1 and 2 may result in harm to patients, forcing them to suffer in silence, unaware of lawful options simply because they do not know how to ask.

Finally, I turn to new clause 9, which presents a number of issues. In the first instance, subsection (1) would permit there to be, in effect, two different standards of proof. That must be legal nonsense. The boundaries

[Dr Shastri-Hurst]

of any legal test or hurdle must be clear. A failure to do so creates a great deal of uncertainty. Furthermore, the proposal to shift the standard of proof from the civil to the criminal, requiring panels to operate on the standard of beyond reasonable doubt, is deeply inappropriate. The balance of probabilities is the cornerstone of medical and civil decision making. To adopt a criminal threshold risks freezing the entire process, creating a very risk-averse system.

Jim Allister (North Antrim) (TUV): With new clause 9, we are talking about the occasion when the final potion is delivered to the patient to kill them. We do not deprive people of their liberty without proving something beyond all reasonable doubt. Why should we deprive someone of their life if we are not going to prove beyond all reasonable doubt that that is their will?

Dr Shastri-Hurst: I am grateful to the hon. and learned Gentleman for his intervention. These are individuals who are making this ultimate choice for themselves. My fear is that this well-intentioned new clause would make the Bill so unusable as to become ineffective. We are not prosecuting a crime here; we are enabling a choice under tightly prescribed circumstances.

While I accept that each of these new clauses in their own way seeks to improve the Bill, we must be cautious about layering protections to the point of paralysis. The Bill as drafted is not a blank cheque—it contains safeguards, panel oversight and rigorous eligibility criteria. Let us not bury its moral clarity under legal clutter. In defending this legislation, we are not abandoning care; we are affirming dignity. Let us do so with confidence and reject these amendments.

Gregory Stafford: On a point of order, Madam Deputy Speaker. I would like your advice. Mr Speaker said that more than 90 people wish to speak in the debate. We have been debating the amendments for an hour and a half and four speeches have been made. If we go to 2 o'clock, that will mean fewer than 20 speakers. I understand that whether a closure motion can be moved is at the discretion of the Chair. If we have not got past, let us say, 20 or 30 Members speaking in the debate, can you give us any indication of whether, if you are still in the Chair, you would accept a closure motion at that point?

Madam Deputy Speaker (Judith Cummins): I thank the hon. Gentleman for his point of order. We will cross that bridge when we come to it. We are currently asking Members to keep their contributions to 15 minutes and that, of course, will be reassessed very shortly—I can give him assurances about that.

Anneliese Dodds (Oxford East) (Lab/Co-op): Madam Deputy Speaker, since I have been in the Chamber, I have received the truly awful news that three people died last night in a fire in Bicester, including two members of the Oxfordshire Fire and Rescue Service. The hon. Member for Bicester and Woodstock (Calum Miller) has had to leave the Chamber to liaise with those on the ground and we both want to take this opportunity, if we may, to convey our deep sorrow for and solidarity with the families of those who have died, and our fervent and heartfelt best wishes to the two firefighters who remain in a serious condition. We are grateful for their heroism and that of their colleagues when, as ever, they ran towards danger to serve us all. [HON. MEMBERS: "Hear, hear."]

I rise to speak in favour of new clause 16 and amendment 14, and I am very grateful for the opportunity to speak. When the Bill first came before the House, I was a Minister attending Cabinet and therefore unable to speak on the subject. I genuinely thank my hon. Friend the Member for Spen Valley (Kim Leadbeater) and every single Member who served for so many hours on the Bill Committee for this incredibly important Bill. I also thank the hundreds of my constituents who have contacted me with their views. I genuinely believe that every single one of them was motivated by compassion and a determination to reduce suffering, and in many cases their views were shaped by their experience of death and of suffering in life. I know that that is the case for many of us in the Chamber as well, so I hope that the same spirit of respect that we saw previously will continue throughout the passage of the Bill, whatever our views may be.

New clause 16(1)(a) would exclude from the scope of the Bill those who do not want to be a burden on others or on public services, and paragraph (b) would exclude those experiencing a mental disorder, including depression. On the former, we have discussed this morning whether it is appropriate to mention international analogies. They will, of course, be instrumentalised by those who have different views about this important subject. I have personally found survey evidence from the Oregon example of people expressing that they felt they were a burden to be highly compelling. I do not believe that it indicates that that was the primary reason why they sought assisted dying, but I believe that it is an important piece of evidence that we need to take into account.

I also believe that we need to look at situations where people who are potentially subject to coercion have been evaluated by professionals in our society, and where we might be concerned about the outcomes. I ask for Members' understanding here.

Tim Farron: On the point that the right hon. Lady has just raised, the Oregon example suggests that in 2023, 47 people who opted for assisted dying gave as one of their primary motivations that they felt they were a burden to others. Is that not a great concern for everybody in the Chamber? Does it not undermine the argument about passing the Bill on the grounds of autonomy? That argument is not accurate, because the provisions affect the autonomy of people who will self-coerce.

Anneliese Dodds: I personally believe that it does. I have heard countless times the phrase, "I do not want to be a burden." I know Members will come to different conclusions about whether it is sufficiently excluded by the Bill. I believe it needs to be on the face of the Bill, so that we can ensure that it is out of scope.

Sir James Cleverly (Braintree) (Con): I tabled an amendment to ensure that the self-defined responsibility to go for assisted dying did not become a rationale. What is the right hon. Lady's view on the impact of intersectionality on this issue? We know that, in practical terms, a number of people do not have full control over their lives. The Mother of the House, the right hon. Member for Hackney North and Stoke Newington (Ms Abbott), made the point that people who are often pushed around by their families and their wider society—particularly women from ethnic minorities—will be at particular risk from the gentle advice or suggestions from authority figures to whom they will be overly deferential, which could lead them into a very dangerous position.

11 am

Anneliese Dodds: I agree with the right hon. Gentleman. I believe it is exactly those individuals who would be more likely to be subject to coercion by others, and I am afraid the evidence does indicate that. Sadly, we can see it in the experience of our courts, which have dealt with so-called mercy killings. I appreciate that many Members in this Chamber would not want that example to be used in the context of this discussion—of course, we are talking about something very different from those court cases. None the less, I believe it is instructive that in those cases, highly trained legal professionals have often described the actions, particularly those of former partners, as motivated by compassion, but when the circumstances have been investigated in detail, there has been substantial evidence of coercion and abuse. It is important that we consider that now.

Kim Leadbeater: Is my right hon. Friend reassured by the fact that the Bill creates a criminal offence of coercion and pressure, which does not exist at the moment? No one is checking for coercion when victims of domestic abuse or others take their own lives under desperate circumstances.

Anneliese Dodds: I am grateful to my hon. Friend for making that point. I believe the Bill has been substantially improved through the many amendments that she and others have tabled. I know that these issues were discussed in detail in Committee, but I have to be honest: sadly, the prospect of a prosecution has often not been sufficient to prevent abuse. I note that in the discussions in Committee, a number of medical professionals mentioned that they often have to assess whether coercion has taken place and that they are confident in that assessment, but there is a huge amount of contestation around whether that confidence is rightly placed or otherwise.

Naz Shah (Bradford West) (Lab): Does my right hon. Friend share my concern that there will only be three hours for a panel, and that the first and second doctors might not actually know the patient or have met them? Their ability to spot coercion will be very limited.

Anneliese Dodds: Yes, I do share my hon. Friend's concern in that regard. Sadly, we all know how perpetrators of coercion operate. They will often school the subject of their coercion in how to respond to questioning, to try to hide what they are doing from others. That is a concern.

Dr Opher: Does my right hon. Friend not see that, in Committee, we were very aware of coercion? That is one of the reasons why we have a social worker on the panel of experts. Additionally, clause 1(2)(b) says it will be necessary to establish that a person

> "has made the decision that they wish to end their own life voluntarily and has not been coerced or pressured by any other person".

It is very clear in the Bill.

Anneliese Dodds: I very much appreciate my hon. Friend's efforts, and those of my hon. Friend the Member for Spen Valley, to ensure that these matters were covered in Committee. Sadly, because of the patterns of behaviour that we see time and again with those who have been subject to coercion, I do not believe that the safeguards go far enough. That is my assessment, and I know that other Members will come to a different view.

Ellie Chowns: Will the right hon. Lady give way?

Anneliese Dodds: I will make some progress, because I know others wish to speak.

I want to speak briefly about subsection (1)(b) of new clause 16, which relates to mental disorder. Colleagues will dispute whether analogies are appropriate, but it is important that the House is aware—this was covered in Committee—that in the Netherlands, which of course has a different regime from the one proposed in the Bill, two cases involving psychiatric suffering were subject to assisted dying in 2010; in 2023, that figure was 138. That is a very substantial increase. I understand that, as was said earlier, it is a completely different set of circumstances in the Dutch case, but I am concerned that there is some confusion about the scope of the mental capacity provisions in the Bill.

Daisy Cooper: I supported the Bill on Second Reading on condition that it would be strengthened to tackle the issue of capacity. Does the right hon. Lady accept that the Bill that we see today is very different from the one that we saw on Second Reading? There is a requirement for capacity. If there is any doubt at all, a doctor is compelled to report that person for additional assessment, and independent advocates have been introduced for people with learning disabilities, autism or mental disorders. Social workers are now included in the panel of experts, specific training on mental capacity is required, and there is a disability advisory board too. Does the right hon. Lady—

Madam Deputy Speaker (Judith Cummins): Order.

Anneliese Dodds: I agree that the Bill has been improved, but there is a difference between mental capacity, at least as assessed by medical professionals, and the presence of mental disorder. I know the Committee examined that subject at length. It was very clear from the discussion in Committee that it anticipated that elements such as being able to assess information and make judgments between alternatives would be covered by the mental capacity provisions—but the evaluation of those alternatives, which can be impacted by mental disorder, is not part of that process. The reality is that those subject to a number of mental disorders—including, sadly, eating disorders—may be highly intelligent and may well be able to carry out many logical procedures to assess information, but their evaluation of the value of their future life and their assessment of the value of bodily control, in relation to other factors, are different from those of someone who is not ill. I believe that issue has not been fully understood.

Naz Shah: Will my right hon. Friend give way?

Anneliese Dodds: I will not give way at the moment.

That is why it is important that that exclusion is put very clearly on the face of the Bill.

Dr Marie Tidball (Penistone and Stocksbridge) (Lab): Does my right hon. Friend agree that clause 2(3) makes it very clear that no one can qualify for assistance under the Bill by reason only of either disability or mental disorder unless they also have six months' terminality and capacity?

Anneliese Dodds: I am aware of what my hon. Friend quite rightly refers to. Of course, any such condition would have to be coterminous with a terminal illness, but we know—the Committee thrashed this out for a long period—that depression is often present at the same time as a diagnosis of terminal illness. We also know that concepts such as "terminal anorexia" have started to be used in certain contexts. That unfortunately suggests that, despite the many protestations of those who understandably support the Bill, there is the possibility that those subject to eating disorders will be pulled within its scope. I am very pleased that amendment 14 would rule that out—it is important that it does so. It is critical that this Chamber sends that message too, given the potential confusion about scope.

I am very grateful for the opportunity to speak to new clause 16 and amendment 14. Above all, I hope we can continue this important discussion, which is critical for so many of our constituents.

Madam Deputy Speaker (Judith Cummins): I call the Father of the House.

Sir Edward Leigh (Gainsborough) (Con): I wish to speak to new clauses 16 and 17. Rather than giving my own views, I think that powerful testimony on behalf of someone who actually runs a care home should be heard by the House. I want to quote, as briefly as possible, Dan Hayes, who runs the Orders of St John Care Trust, which runs care homes in Lincoln generally and in my constituency:

> "we believe that the Bill as drafted is flawed, and the risks to older, vulnerable people, residing within social care environments are substantial.
>
> We believe that any assumption by those drafting the final legislation that it is not intended for use by those living with conditions regarded as part of the ageing process, would be mistaken. Any legislation would be immediately tested and assumed to be accessible to such a cohort of people.
>
> To that end we believe that in order to provide the necessary protections to such a vulnerable part of our society, the Bill must be explicit in its reference to older people living in residential services."

That is why these new clauses are so important. He continues:

> "The Bill must take account of the current unfairness and instability at the heart of our social care system, and question whether such legislation can be introduced whilst such problems exist.
>
> The Bill must recognise that an individual health/social care professional's ability to remove themselves from the process of Assisted Dying is so difficult, that specific exclusion of the care home sector should be a feature of the Bill. In any case, organisations, and sites, should be given the ability to exclude themselves from the act of an assisted death without prejudice to their approval as providers of services to the state."

We have experience of that, with regard to Catholic adoption agencies. There is a real risk that some care homes may feel they have to withdraw from this sector. I will carry on quoting:

> "Those that fund their own care pay substantial sums, often saved for over a lifetime—including property wealth. These savings will have been set aside for retirement and to pass on to loved ones. Instead, they are used to fund the costs of their own residential care, and to substantially subsidise the state.
>
> We see the real prospect that those that might fit the criteria for assisted dying under the Bill, but have no wish to accelerate their death, would feel an immediate dilemma between prolonging their own lives, and the future quality of life of their loved ones. For illustrative purposes, the six-month period stated within the current Bill would equate to between £25,000 and £40,000 of expense borne by an individual paying for their own residential care in the current system.
>
> Failings in the system mean that older people who should not be in hospital are held there, causing a burden to the NHS, and Local Authorities face an ever-growing proportion of funding needed to support social care, without a proportionate increase in funding from central government."

Lola McEvoy: Will the right hon. Gentleman give way?

Sir Edward Leigh: I wish to be mindful of other people, so I will proceed and make this one simple point on behalf of care homes. Mr Hayes continues:

> "During the pandemic, we saw the appalling attempts at a widespread use of 'Do Not Attempt Resuscitation' arrangements for older people. This is a clear demonstration that an existing broken system places a lower value upon the lives of older people than of others."

This is the important point:

> "Relationships within residential care for older people are both professional and intimate. Carers, Care Leaders, and Service Managers are all competent health and social care professionals, but they are also friends and confidantes of those that live within social care services. The relationships are familial in the sense of contact for hours each day and the extension of support to ordinary, everyday issues outside the scope of normal healthcare professionals.
>
> Our employees deliver loving care and build relationships in a way that residents come to depend upon and take comfort from. Such relationships are key to excellent care provision, and these important relationships enhance and prolong lives by providing a sense of purpose and place to older people."

I have been around these care homes. They are fantastic places, with such love and such care for the most vulnerable in society. My Hayes then continues:

> "In such a setting, it renders the ability for an individual to refuse to partake…as useless.
>
> In an environment such as a care home, there is no way in which a professional could be fully 'separated' from assisted dying, should a resident they work with closely seek to enquire about or make a request.
>
> Imagine a scenario where an individual living in social care is at the point where they will be provided with the approved substance to bring about their own death: In a care home, this is likely to be in their own room, which will be in close proximity to many other older people who live within that setting. It will be commonplace and understandable that the magnitude of the event will mean that the individual will wish to have company and comfort up to and immediately before/during the period in which the substance is taken.

> A request for the company of a care professional will create a substantial moral dilemma for that person, profoundly so if they are individually opposed to Assisted Dying."

That is the choice that these loving care workers will have to make—that would be the pressure on them. He goes on to say:

> "Even where they are not, it will mean that they will intimately witness the death of someone with whom they have a strong bond, with that death having come about through facilitation, rather than naturally."

Imagine the pressure on the workers in that care home.

11.15 am

Mr Hayes continues:

> "The scenario is made worse by the prospect of an assisted death not resulting in a quick nor painless death. There are examples from other jurisdictions of significant complications leading to painful deaths and deeply traumatic experiences for loved ones. Social care professionals should not be exposed to the risk of such experiences."

In conclusion, he asks the House of Commons

> "to consider the unworkable nature of individual exclusion from the processes of Assisted Dying for social care professionals. Consequently, specific exclusion of the care home sector should be a feature of the Bill. In any case, organisations, and sites, should"—

and must—

> "be given the ability to exclude themselves from the act of an assisted death."

Tom Rutland (East Worthing and Shoreham) (Lab): I rise to speak in support of new clause 10, which is about choice. In fact, the Bill is about choice: choice at the end of life and choice to have a dignified death. It is about a choice that is currently being denied to many in untreatable, excruciating pain at the end of their lives—a choice that the majority in this country would want for themselves.

New clause 10 is in that same spirit. It would offer practitioners a choice, by ensuring that there was no obligation on any person to provide assistance to a terminally ill adult seeking an assisted death. That includes those such as my constituent Aimee's grandmother, who repeatedly asked her, "When will it end?" from the bed in her hospice, where, despite the best efforts of staff, they were medically unable to treat her constant pain and legally unable to make good on her wish to, in her own words, be helped to go.

The Bill allows doctors to choose not to participate in the assisted dying process if they so wish. The new clause would improve it by extending that provision to all registered medical practitioners, health professionals, social care professionals, pharmacists and pharmacy technicians. It would also make it clear that no person is under any duty to act as a witness or a proxy in the process. It would further amend the Employment Rights Act 1996 to ensure that no one could be subjected to detriment by their employer for providing assistance to those seeking an assisted death or for choosing not to do so. That is a good thing: it respects people's choices.

Some will not want to aid someone seeking an assisted death because of religious or other principled objections, but some, like my constituent Karen, will want to. Karen wrote to me setting out her father-in-law's terminal diagnosis of a brain tumour, his fear of losing control of mental and bodily functions as his condition progressed and his hope that the Bill would pass in time for him to benefit from it.

Karen is not simply a relative of a terminally ill person; she spent years working in palliative care, watching people lose their independence and dignity as a result of their terminal illness, with patients asking her how they could end the suffering for both themselves and their families. She was heartbroken to witness their distress and pain over days, weeks or even months, knowing that nothing could be done for them. In their painful final stretches, some felt suicidal and some felt a burden. For that reason, I must oppose new clause 16, which would rule ineligible for assisted dying anyone who is substantially motivated by a number of factors, including feeling a burden, or suicidal ideation.

Sir John Hayes: I am surprised by the hon. Gentleman's objections to new clause 16, given that we have been assured throughout that the Bill would apply only to people who were terminally ill with six months to live. Is he really saying, therefore, that he does not want a new clause that would rule out from assisted death people who feel that they would be a burden on others, people with a mental disorder and people with a disability? His argument for choice is exactly the argument that in other jurisdictions has led to the expansion of assisted death to just those kinds of people.

Tom Rutland: I am grateful to the right hon. Gentleman for that intervention, because it allows me to continue making an argument that will address those points. First, substantial motivation is vague, undefined and legally imprecise. This new clause is a blunt instrument and an attempt to shut the door on entire groups of people accessing an assisted death. How would one establish what a substantially motivating factor in any individual case is? No motivation exists in a vacuum, and feeling a burden can co-exist with physical deterioration and untreatable pain. Secondly, if suicidal ideation is to think about dying by taking one's own life, would that not encompass everyone considering assisted dying?

Dr Sandher: I think today of Norman Ward, who in 2020 shot himself while terminally ill because of the terrible pain that he faced. Does my hon. Friend agree that under subsection (f) of new clause 16, Norman Ward would have been unable to access the choice that would have ended his suffering?

Tom Rutland: I agree with my hon. Friend.

Similarly, I cannot support amendment 102, which would require doctors to ensure that there were no "remediable suicide risk factors" before conducting a preliminary discussion with the patient. There is no clear legal or clinical definition of the term "remediable suicide risk factor", and the Bill already includes multiple checks on mental capacity and mental illness, including by independent doctors and a specialist panel. The vagueness of this amendment risks wrecking this much-needed Bill.

I emailed Karen again yesterday to ask if I could refer to her in this speech. Her father-in-law had sadly died in the time that had passed between her initial email and our exchange yesterday. The Bill was not passed in time for him and he could not benefit from it. However, Karen hoped that his story could make some

[Tom Rutland]

small contribution to changing the law. There do not need to be more people in Karen's father-in-law's position, or in Aimee's grandmother's position—they can have choice at the end of life, and our brilliant palliative care workforce, like Karen, can have choice on the kind of care they provide too.

David Smith: Will my hon. Friend give way?

Tom Rutland: I am afraid I must make progress.

I therefore hope that Members across the House will join me in supporting new clause 10, strengthening the Bill and reinforcing the fact that choice, for patients and practitioners, is at the heart of this legislation, and I hope they will oppose the amendments and new clauses that would wreck the Bill and put that choice at risk.

Several hon. Members *rose*—

Madam Deputy Speaker (Judith Cummins): Before I call the next speaker, I will be asking Members after him to limit their comments to eight minutes.

Tom Gordon (Harrogate and Knaresborough) (LD): I start by thanking the hon. Member for Spen Valley (Kim Leadbeater) for introducing the Bill and for giving me the opportunity to serve on the Bill Committee.

I rise to speak in favour of my amendment 4, which goes to the very heart of what the Bill is all about: dignity, compassion and choice at the end of life.

Pippa Heylings (South Cambridgeshire) (LD): My hon. Friend is right to point out that compassion and fairness for those who are terminally ill are rightly at the heart of the Bill. Does he agree with my constituents who would like to see it extended to those terminally ill with motor neurone disease and neurodegenerative disorders, to give them choice and dignity, too, by extending the eligibility period? *[Interruption.]*

Tom Gordon: I thank my hon. Friend for her intervention. It was really interesting how the debate was conducted on Second Reading and in Committee, and how we were meant to be having that respectful debate, and it is disappointing to hear comments from opponents already.

Amendment 4 seeks a simple yet crucial change to extend the eligibility period for those with neurodegenerative conditions, from six months to 12 months, something that is already reflected in legislation in five of six Australian states. My amendment mirrors the wording used in that legislation, and it is based not on conjecture but on medical reality, international precedent and, most importantly, the lived experiences of those facing some of the most harrowing diseases imaginable.

Amendment 4 would not expand the Bill's reach beyond terminal conditions; it simply acknowledges that for people with conditions such as MND and other neurodegenerative diseases, the current six-month prognosis requirement creates a cruel and unnecessary barrier.

Liz Saville Roberts (Dwyfor Meirionnydd) (PC): I am sure that the House will be interested to note that the jurisdiction of Scotland, as well as the Crown dependencies of the Isle of Man and Jersey, have variations that are different from what has been discussed. Will the hon. Member join me in commiserating with the family of Iola Dorkins, a campaigner I mentioned back in November? She died of motor neurone disease on her birthday last week. Let us remember that we are doing this for real people who are undergoing real suffering at the end of life.

Tom Gordon: The right hon. Member makes a pertinent point about other jurisdictions and the different Bills and conversations around them that they have. I tabled my amendment in order to ensure that we have that debate in this place. I extend my condolences to the family.

These are progressive, irreversible diseases; their trajectory is well understood; and their toll is devastating. People with MND, for instance, often face a relentless loss of muscle function, leaving them unable to move, speak or even swallow. Before they reach the six-month prognosis threshold, they may already be enduring intolerable suffering. Crucially, many will lose the capacity necessary to make an application before they ever qualify.

The Bill already contains the most robust protections of any assisted dying Bill in the world, with mandatory capacity assessments, a multi-step approval process and a clear requirement for terminal illness. We have gone further than any other jurisdiction in terms of safeguards.

Mr Angus MacDonald (Inverness, Skye and West Ross-shire) (LD): May I posit the idea that what my hon. Friend is suggesting, and what the previous intervention was suggesting, is a slippery slope? It is an enormous concern, and I suspect that in a few years' time we will see a very different Bill.

Tom Gordon: I thank my hon. Friend for his intervention. The amendment is designed to stop our having a conversation about eligibility after this Bill. I want to see a Bill that stops the argument about a slippery slope and gives equitable access to people with all health conditions.

David Smith: Will the hon. Member give way?

Tom Gordon: I will make a little progress.

We have gone further than any other jurisdiction in terms of safeguards. Why, then, if we are satisfied that our safeguards are robust, are we excluding those with neurodegenerative diseases—people who are terminally ill—on the basis of an arbitrary timeframe? We say that the Bill is about choice, but for someone who has already lost the ability to speak or move and who knows that they are on a rapid decline, what choice do we offer? Are we saying, "Wait until your prognosis hits six months, if a doctor can say so with confidence, and then hope that you will still have the cognitive ability to apply"?

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

Tom Gordon: I will make progress.

Let me speak to the reality of my amendment with a story from a constituent who does not wish to be named. She wrote to me about her brother, who died at age 58 from MND. Prior to his diagnosis, he was strong, healthy and, as she put it, a lot of fun. He was a great family man, but it was dreadful to watch his illness progress, and it had a profound impact on the family. It took 18 months of effort, worry and deep distress before he finally passed away. He wanted to have control over the time of his death, knowing what was to come. My constituent wrote:

> "A difficult subject for most of us to contemplate, but in his particular case the possibility of assisted dying would have given him much comfort."

Lola McEvoy: Will the hon. Member give way?

Tom Gordon: I will make a little progress, as I was in the middle of a quotation. It continues:

> "Unless you are actually affected by something as desperate as MND, you cannot understand what it really means to have such an option."

My constituent is right. We can debate legal safeguards, ethics and precedents all day in this Chamber, but for those who are living with devastating diseases, this is not theoretical; it is personal, it is urgent and it is real.

Christine Jardine: This is a very personal one for me, because much of my motivation for supporting the Bill comes from having watched a member of my family die of motor neurone disease. Although perhaps it would have been preferable if motor neurone disease and other degenerative diseases could have been included, I accept that we do not want to go down the slippery slope. However, there is a difference between extending the Bill to degenerative diseases such as motor neurone disease and extending it to other conditions. Perhaps we could consider supporting that, because I would not want anyone to go through what I witnessed, without the choice to end it without going through more pain.

11.30 am

Tom Gordon: I thank my hon. Friend for that powerful and compelling intervention.

We risk creating a two-tier system. We say that we want to fix the status quo because we know that it is not working, but if the Bill forces people such as my constituent's brother to consider dying earlier—or worse, to have to travel abroad for an assisted death in another far-off, distant country under different laws—then have we really changed anything? We may be telling people with cancer that they can access a dignified death under the Bill, but also telling those with neurodegenerative conditions such as MND that they must either endure prolonged suffering or act prematurely, just to stay ahead of a ticking clock. That is not justice, in my view, and it is certainly not compassion.

International experience backs up the amendment. In Victoria, where a 12-month limit applies to neurodegenerative conditions, only 7% of applicants lose capacity before they can proceed. In New Zealand, where the six-month threshold remains, many people are excluded because they lose that ability too soon. We know that MND takes more than 2,000 lives a year in the UK alone—six people every single day. I ask colleagues not to turn away from those people; not to dismiss their fears, their hopes or their pleas for fairness.

Several hon. Members *rose—*

Tom Gordon: I will make some progress.

The amendment is not about eroding the careful work that the Bill Committee has done to expand the rigorous safeguards already in the Bill; it is about ensuring that some people with the cruellest terminal conditions are not left out of the options that we are seeking to give others.

David Smith: Will the hon. Gentleman give way?

Tom Gordon: I am bringing my remarks to a close.

If we believe in dignity, let us ensure it is a dignity that includes everyone; if we believe in autonomy, let us not deny it to those who may lose their voice tomorrow; and if we believe in compassion, let it be a compassion that recognises the lived reality of all terminal illnesses and does not consign those with MND to the status quo.

Florence Eshalomi: Mindful of time and of the need to allow other colleagues to speak, I have been carefully to ensure that my speech is short. I will therefore not be taking any interventions.

I voted against the Bill on Second Reading, on the grounds that there were inadequate safeguards against the coercion of minority communities. That was based on my belief that, if we are to legislate for something as serious as the end of someone's life, then the bar that the legislation must reach in order for it to be deemed safe needs to be much higher than it is in other areas. In the time since, I have followed closely the scrutiny that the Bill has received at Committee and on Report. I had hoped that my concerns would be addressed, but I am sad to say that I am even more worried now than I was then.

Before getting to the new clauses and amendments that would provide important safeguards, I want to state again that I do not think the Bill is the appropriate mechanism for a national decision of this magnitude to be made, and ultimately, any decision on it should be led by the Government and the clear will of this House, not on promises made to people without an elected mandate.

I pay tribute to the work of tireless campaigners on a number of important issues in relation to the scrutiny of this Bill since Second Reading. That work resulted in many amendments and new clauses being tabled by Members from across the House to attempt to strengthen the protections for at-risk groups. As I alluded to, I sadly do not have enough time to speak to all of those that I support, but I am grateful for the efforts of the many who have led and spoken in this debate.

I will speak to amendment 16, which stands in my name. It would make it explicit in clause 28 that there would be no obligation on any care home or hospice that is regulated by the Care Quality Commission or the Care Inspectorate Wales to provide assisted dying on its premises. I understand that my hon. Friend the Member for Spen Valley (Kim Leadbeater) has tabled new clause 10 to replace clause 28 and thereby ensure that there is no obligation on anyone to provide assistance. While I welcome the expansion of protection that that provides to practitioners who do not wish to provide assistance, I do not believe that it is comprehensive.

[Florence Eshalomi]

Dr Jamilla Hussain, a palliative care consultant working predominantly with ethnic minority communities in Bradford, gave oral evidence to the Bill Committee. She said:

> "I have gone into those communities and I have spoken to them about this Bill. What they say overwhelmingly to me is, 'We're scared. We're really fearful that this is going to result in a disproportionate impact on our community. We have seen that through covid and we're so scared."—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee,* 29 January 2025; c. 187, Q245.]

Heartbreakingly, she also said:

> "Almost every week, one of the first things I have to reassure patients about is that I cannot legally do anything to shorten their life. This is front and centre of the fear for those patients and we see it all the time."—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee,* 29 January 2025; c. 190, Q247.]

This is not an academic or theoretical risk. Are we really prepared to sideline those unheard voices and risk embedding further inequalities in healthcare as we legislate?

We are all elected to this place to elevate the voices of those who feel that they are furthest away from power. If we are to achieve that, we must make decisions that honour their experiences, and legislate to protect them, but if hospices are unable to opt out of a collective policy of providing assisted dying, the people who already feel ignored by healthcare systems are more likely to fear accessing the care that they need at the end of their life. That would create further unnecessary suffering, and I know that we are all united in wanting to avoid that.

I do not doubt the good intentions of any Members choosing to support this Bill, and I thank the many constituents, on both sides of the debate, who have contacted me. However, we politicians have to be clear that Members with valid concerns about this Bill are raising them not because of some ideology or religious belief, but because we recognise that if this Bill passes, it may impact everyone, not just those who wish to die. It is not wrong or scaremongering to consider wider family life, relationships in which there are feelings of burden or coercion, and vulnerable women and people from the BME community at the end of their life. It is not wrong or scaremongering for us politicians, as we continue to receive correspondence from our constituents about the broken state of our NHS and social care, to think carefully about a Bill that may alter the relationship between doctors and their patients.

It is frankly insulting to disabled people and hard-working professionals up and down the country to have their many valid concerns about this Bill dismissed as religious beliefs. Sadly, I have come to the conclusion that instead of giving a universal right to dignity in death, this Bill would reinforce the health inequalities that deprive so many from our vulnerable communities of dignity in life. I urge Members to keep that at the forefront of their mind as we vote today, and to reject this Bill.

Sarah Bool (South Northamptonshire) (Con): I am grateful to speak in this debate, and I will focus on three amendments: new clause 9 and amendments 51 and 38. To save time, so that other Members can speak, I will not take interventions.

New clause 9, which is in my name, would essentially establish the standard of proof—namely, the degree of certainty and the amount of evidence—required in decision making under this Bill. Let me put that into context. Various standards of proof are used in law. At the very lowest end of the scale is reasonable belief, which is a belief that would be held by an ordinary person in the same circumstances. There is then the civil standard of proof, known as the balance of probabilities, which is sometimes known as the 50% plus one rule, or "more likely than not". Finally, we have the most serious standard: the "beyond reasonable doubt" test, which applies for criminal cases. That goes further than the balance of probabilities, and requires the person to be sure.

Given the lack of clarity and confusion in Committee about whether the test for doctors should be reasonable belief or the balance of probabilities, I have proposed the new clause. As Members will see, it has three parts. Subsection (1) relates to the assessment by the co-ordinating and independent doctor. As Members will see, it has three parts. Subsection (1) relates to the assessment by the co-ordinating and independent doctor. Here I argue that the balance of probabilities test should be used, because it feels perhaps overly punitive to exclude someone from the process at the initial stage if it is more likely than not that they will meet the test, but there are some doubts. However, under subsection (2), when the assisted dying review panel is making its assessment, it must use the "beyond reasonable doubt" test. Given that, at this stage, it will have all the reports from the doctors and professionals, if it is not sure beyond a reasonable doubt, the application should not be approved. That is an essential safeguard.

Subsection (3) relates to the moment of supplying the lethal drugs. The doctor is required to satisfy themselves that the person has capacity and a clear, settled and informed wish to end their life, and is not being coerced. At that point, the "balance of probabilities" test does not suffice; it must be "beyond reasonable doubt"—this is life and death.

All hon. Members need to ask themselves whether, without this new clause, they are happy with someone being provided with lethal drugs to end their life by our NHS in circumstances where we are not absolutely certain of their intention. I acknowledge, for the record, that the hon. Member for Solihull West and Shirley (Dr Shastri-Hurst) has made an objection to the use of "beyond reasonable doubt", asking whether it is right to apply a criminal standard of proof when a civil standard may be flexible enough. However, I note that in the House of Lords in re B case in 2008, Baroness Hale said,

> "There are some proceedings, though civil in form, whose nature is such that it is appropriate to apply the criminal standard of proof,"

and a subsequent 2012 case affirmed that.

If we stay silent and let the assisted dying review panel and the courts try to work out whether they should interpret "satisfied" as meaning satisfied to the civil or criminal standard, it would merely result in numerous litigation battles. On a matter as serious as death, Parliament must provide the clarity needed. Without it, the Bill is simply not safe.

The second area I am focusing on is informed consent and complications, through amendment 51 to clause 11. The amendment would impose a duty on assessing doctors to inform individuals seeking an assisted death of any reasonable body of medical or scientific opinion indicating that the prescribed substance carries risks of complications, including pain. Clause 11 requires doctors to explain how the drug is expected to bring about death, and to discuss with the individual what ought to be done in the event of complications. However, it omits a critical element identified by the General Medical Council in its guidance on consent: the obligation to communicate known risks of harm and the uncertainty surrounding those risks. A patient cannot be said to give informed consent if they are not made aware of the full range of potential complications, including pain, distress and the possibility that the drug may not act as expected.

The state of Oregon's most recent data shows that complications were recorded in approximately 3% of cases in 2023, but historical data shows a complication rate of 11%. Since the introduction of the law there, there have been nine recorded incidents of patients regaining consciousness after ingesting the prescribed substances, and time to death has ranged from three minutes to 137 hours—that is, more than five and a half days. Canadian studies indicate that around 5% of oral assisted deaths result in a prolonged and often distressing process. In some instances, medical intervention is required. Evidence also suggests that younger adults, particularly those aged 18 to 24, are more likely to experience extended and unpredictable deaths.

Furthermore, not all complications may be outwardly evident. High doses of barbiturates, combined with paralytic agents that suppress all voluntary muscle movement, may result in what outwardly appears to be a calm and peaceful death, but that may conceal considerable psychological suffering. The hon. Member for Spen Valley (Kim Leadbeater) talks about offering choice, but a choice made in the absence of information is not true autonomy; it is abdication. Making a meaningful decision requires the individual to be aware of not only what is intended to happen, but what may plausibly go wrong. In both Oregon and California, legislation explicitly requires that patients be informed of any known risks associated with the medication to be administered, so why would we adopt a lesser standard here? The amendment simply calls for honesty.

Finally, but briefly, I also want to add my support for amendment 38, which clarifies that an individual who is not already terminally ill under the definition of clause 2(1) cannot qualify by refusing standard treatment or taking steps to induce a terminal condition. I live with type 1 diabetes, which, for the record, is a progressive illness that cannot be reversed by treatment. This condition is managed—or not, in cases of extreme stress—solely by the individual. I therefore recognise that the amendment is an incredibly important protection. Diabetics face multiple daily injections, and have to think about and monitor everything that they do, 24/7, and they can be at risk of diabetic distress, or even develop disordered eating. That could prove fatal if standard treatments are not accepted. They should never be offered assisted suicide; they could recover with the right support. I have spoken to the hon. Member for Spen Valley about my concern that conditions like diabetes may be caught unintentionally. The amendment would be a step to protect those who may be unable to protect themselves using standard means. Diabetes and anorexia have been a reason for assisted suicide in Oregon, so please be aware of what could happen.

11.45 am

On a personal note, not long after I was diagnosed as a type 1 diabetic, I suffered diabetic distress. I did not know how I could continue with this condition, but I convinced every single person at my workplace that I was absolutely fine. It was only because my parents caught it that I am in this position today, and was able to get support. Please think seriously about the unintended consequences, and protect vulnerable people like me.

Dr Tidball: My decision to support the Bill on Second Reading was one of the hardest I have ever had to make. It required me to go into the very depths of myself and draw on my experience as a child in excruciating pain, as well as the extensive poignant experiences shared with me by my constituents. As I said then, my support was conditional on specific changes being made to the Bill in Committee. I am pleased to say that all those changes have been made. As a member of the Committee, I can tell the House that it was the most extraordinary cross-party deliberative process I have ever witnessed in my 20 years of analysing legislation as an academic and policy researcher working in disability law and policy. In Committee, I worked to strengthen the voices of disabled people, and their protection under the Bill. I moved motions to introduce clause 20 on independent advocates and clause 44, which would create a disability advisory board. These provisions are augmented today by amendments 75 and 91, tabled by my hon. Friend the Member for Spen Valley (Kim Leadbeater).

Clause 20 would establish the role of independent advocate. They would advocate for qualifying persons who engage with the Bill, so that those persons can effectively understand their options around end of life care. This would empower disabled people to be treated with the dignity and respect that we deserve. These independent advocates would be required to undertake specialist training, and would be available regardless of whether the individual is ultimately found to be eligible to request an assisted death.

Sir John Hayes: Will the hon. Lady give way?

Dr Tidball: I will make progress, out of respect for all those on both sides of the House who wish to make a speech.

The clause flowed directly from evidence that we heard from oral witnesses, including leading disability scholars and disability policy experts. In conjunction with amendment 75, which is before us today, those with autism, along with a learning disability or a mental disorder as defined under the Mental Health Act 1983, would all qualify for the services of an independent advocate. Amendment 75, which defines a learning disability, would also apply to clause 7, which provides for specific, up-to-date training for registered practitioners on reasonable adjustments and safeguards for autistic people and people with a learning disability.

In Committee, I was grateful for the support of my hon. Friend the Member for Bexleyheath and Crayford (Daniel Francis) and, to my delight, the hon. Member for East Wiltshire (Danny Kruger) for these independent advocates, and for the Committee's unanimous support

[Dr Tidball]

for clause 44, which would set up the disability advisory board. That advisory board entrenches the voices of disabled people in the Bill, embedding a long-term and iterative structure for it to report on the Bill's implementation and its impact on disabled people to the Secretary of State. Crucially, the board must consist of disabled people and representatives of disabled people's organisations.

To build on those clauses, amendment 91 expands the duty to collect additional information about whether, immediately before death, the person seeking assistance had a disability as defined in section 6 of the Equality Act 2010, other than the disability amounting to terminal illness as defined in the Bill. So often, control is taken away from disabled people in all sorts of circumstances. I passionately believe in inclusive healthcare for disabled people. Together, all those measures will create a solid foundation to enable disabled people to have a strong voice when advocating for themselves about their choices on end-of-life care and, importantly, a seat at the table in shaping the monitoring of the Bill and providing continued scrutiny and accountability.

To conclude, there were many moments in Committee when I reflected on how I would want to live a good death, but the most poignant was when Julie Thienpont described the death of her terminally ill husband, Guy, who sought an assisted death in Spain:

> "Guy had always been a bit of an old cowboy, and he always said that he wanted to die with his boots on. I am proud to say that that is what he did. At the end, we were holding hands, and I said to him, 'Don't be afraid.' He said, 'I'm not afraid,' and he winked at me just before he closed his eyes."—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee,* 30 January 2025; c. 258, Q334.]

May we all have the opportunity to choose a good death, wearing our cowboy boots with the love of our life by our side.

Liz Jarvis (Eastleigh) (LD): I am grateful for the opportunity to contribute to this vital debate. It is imperative that we get the Bill right and that the protections and procedures are watertight. I thank my constituents on both sides of the debate who have written to me.

I support amendment 4, tabled by my hon. Friend the Member for Harrogate and Knaresborough (Tom Gordon), which would allow those with neurodegenerative diseases to be eligible for an assisted death if they are within 12 months of dying. Nigel Hartley MBE, the chief executive officer of Mountbatten Hampshire hospice in my constituency, told me that palliative care and assisted dying are not and should not be at odds with each other. Palliative care can provide incredible support. I am very glad that this debate has reopened the national conversation about funding for palliative care. However, as I know from my personal experience with my mum, who died last March after a seven-year struggle with Alzheimer's, sometimes palliative care can only go so far. Amendment 4 recognises that those with neurodegenerative illnesses deserve the same compassion, control and dignity as others at the end of their lives. By extending the timeframe to 12 months, they will be given more control over their ultimate decision.

I support new clause 10, which extends the right for any professional to opt out of providing assistance under the Bill, and extends the protections to a broader range of professionals who may be involved.

I also support amendments 59 and 62, which relate to training on domestic abuse. Those amendments are critical to ensuring that the co-ordinating doctor can identify signs of domestic abuse. The inclusion of training enhances the Bill's protective framework, as no medical professional without specific and up-to-date training on domestic abuse will be able to serve as a co-ordinating doctor. Importantly, amendment 74 defines "domestic abuse" using the language of the Domestic Abuse Act 2021, which explicitly includes coercive, controlling and economic abuse.

Amendment 63 removes any ambiguity about the scope of eligibility, and makes it clear that only terminal illness qualifies under this legislation. That clarity is essential to maintaining public trust and ensuring that the Bill is not open to misinterpretation or misuse. It can be incredibly difficult for people with disabilities, and their families and carers, to get their concerns across—they can often feel unseen and unheard—so the amendment is vital.

Finally, I pay tribute to the hon. Member for Spen Valley (Kim Leadbeater) for her work on the Bill and her tremendous courage, determination, willingness to engage and resilience. As others have said, the decision before us is fundamentally about whether we believe in an individual's right to have choice at the end of their life. I know what my mum would have said.

Rachael Maskell (York Central) (Lab/Co-op): I rise to speak to amendments 26, 45 and 46, which stand in my name and the names of other Members. I am grateful for their support.

On amendment 26, hospice care is not a formulation of care, but a clinical setting where palliative care is delivered, so I trust that the House will accept my amendment in the interests of accuracy.

On amendment 45 and consequential amendment 46, the literature points to complex clinical decision making—which the subject of the Bill is—being safer if it happens in the context of multidisciplinary teams, as was advocated for by the professional bodies at the very start of the process. Such a context screens out unconscious bias and provides for clinical accountability with robust interdependency. It demands a deliberative process and it safeguards clinicians and patients with more secure outcomes. I have talked extensively to the professional bodies and clinicians, and I have read the academic evidence. In drawing on best practice, this amendment would provide such safeguards and ensure that the patient is at the heart of the process.

Members will know from the evidence given to the Bill Committee that the initial assessment is the most important part of the process, and clinicians and professional bodies do not understand why psychiatrists and social workers are being placed in a quasi-judicial role, rather than being used for their clinical and social expertise. The process makes the wrong assumptions. Without the amendments, there is a predication towards an assisted death, rather than the Bill recognising the insecure position that someone with a terminal illness finds themselves in and the safeguards that are required. There are many reasons for suicidality, and they should be explored.

In clinical practice, should someone determine that they want to end their life for whatever reason, a clinician would seek to ensure that the right professionals were involved in the care of the person, with exploration, diagnosis and, where necessary, therapeutic and pharmacological interventions.

Sir John Hayes: Will the hon. Lady give way?

Rachael Maskell: I will not. Dr Lade Smith, the president of the Royal College of Psychiatrists, could not have been clearer, and academic research says the same: when someone is in receipt of a terminal diagnosis, there is frequently an episode of depressive disorder. Dr Price said in evidence:

> "Those who had a wish to hasten death were 18 times more likely to also feel suicidal".—[*Official Report, Terminally Ill Adults (End of Life) Bill Public Bill Committee,* 30 January 2025; c. 275, Q359.]

They say that mental disorders are treatable. The spike in suicidal ideation and action is highest in the first few months following terminal diagnosis and then dissipates with time or intervention. Again, that is evidenced. People change their mind and no longer want to die.

As with other aspects of the Bill, poor care, poor pain management and poor symptom control—or the fear thereof—are reasons why people seek to end their life. That can be palliated. Colleagues must recognise the paucity of mental health provision given to somebody when they receive a terminal diagnosis. Often there is no psychological aftercare. People are failed, but that should not be a reason to die.

I ask for a panel, which would include a social worker, to assess the psychological needs of a patient. They are experts in detecting coercion, whether intrinsic or extrinsic, and understanding people at their most vulnerable with a fusion of complex emotions, anxiety and fear. Solutions can be found by them. There would also be a psychiatrist. Depression, anxiety and fear are natural responses to trauma, but they can be treated with the right interventions, if detected at the point that somebody expresses a wish to die, and a person can have a wish to live. The travesty of getting it wrong is unconscionable.

There would be a palliative care consultant who is registered on the GMC's specialist register. They would understand the actions that could alleviate someone's suffering. Evidence to the Bill Committee from Sue Ryder showed how poor provision led to someone considering an assisted death. Likewise, the president of the Association for Palliative Medicine, Dr Sarah Cox, said:

> "We know that effective palliative care can change a terminally ill person's point of view from wanting to die to wanting to live."—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee,* 28 January 2025; c. 70, Q84.]

That is evidence. It is a point I have heard from all leaders on the Commission on Palliative and End-of-Life Care. These are the specialists who know how to palliate the physical, psychological, social and spiritual problems of a patient, and they have techniques that many people have not had access to, because of poor provision.

The palliative care commission reported on Tuesday and I urge hon. Members to read its evidence-rich report, which draws on best practice. We reported that excellence in end-of-life provision is achievable, but that too many people are not getting access to it. Without that, I fear that the Bill only leads the patient down one route—to die. This is not a choice at all, but a path to an assisted death.

12 noon

I also ask for two doctors—a generalist and a specialist—one of whom is the co-ordinating doctor. Yesterday, the Royal College of Physicians stated that there is inadequate protection of patients and professionals in the Bill:

> "Notably the proposed mechanisms of decision making are not in line with good clinical and professional practice… Parliament must address these critical issues in the legislation or risk failing to protect vulnerable patients and uphold the integrity of clinical practice."

This week, the chair of the Royal College of General Practitioners said that it has

> "real concerns about the practical and legal implications"

of the Bill. I seek to address the assessment process through my amendments.

If the Minister for Care thinks that just two days of training for a doctor is sufficient, I can tell him that that will not provide them with the necessary competencies. However, the impact assessment suggests that the training to be provided will be just 90 minutes online, with a 60-minute interactive training session. That is simply not good enough.

Poor medicine makes assumptions, and this Bill certainly does that. It assumes that somebody wants to die, but it is a clinician's duty to have an open and inquiring mind, and to seek out reason, not to assume. That is recognised by the Government's suicide prevention strategy. Only through examination can we establish why someone wants to die. Chapter 8 of the palliative care commission report highlights that 24% of the population

> "do not know much about or have not heard of palliative care",

as is set out in a study by King's College London. The Bill presumes only an assisted death, not choice.

Finally, how should this be done? It should be through separate or joint assessments, and then a panel meeting to deliberate—not a quasi-judicial panel, but evidence-led assessments where real choice is offered. Let us listen to the experts and hear their collective voice: the Bill is unsafe. That is why professional bodies are speaking out against the Bill. My amendments would nudge it to a safer place, but the scale of the concern far exceeds this change. Colleagues, we must follow the experts' evidence.

Sir Jeremy Wright (Kenilworth and Southam) (Con): In view of the number of hon. Members who wish to speak in the debate, I will restrict my remarks to amendments 47, 48 and 49, which stand in my name and the names of others. The amendments focus on the stage in the process that involves the multidisciplinary panel established by clause 14, and their purpose is to make that system work better.

A panel is intended to be an additional safeguard. The hon. Member for Spen Valley (Kim Leadbeater) has made that very clear, and such panels are the successor to the involvement of a High Court judge assessing the merits of each case. The role of the panel is to determine whether it is satisfied of the matters set out in clause 15(2). Some of those matters are procedural—for example, whether the person seeking the certificate is aged over 18 or is resident in the UK, or whether declarations and assessments that should be made have been made. Others are matters of judgment, including

[Sir Jeremy Wright]

professional judgment, such as whether an illness is terminal or whether the person applying for a certificate of eligibility has the mental capacity to do so.

The remaining category of matters to be considered are matters of broader judgment, and I suspect those are likely to be where the panel focuses most of its attention, particularly the final two listed in clause 15(2): first, whether

> "the person has a clear, settled and informed wish to end their own life"

and, secondly, that there is no coercion or pressure from anyone else. On those matters, the panel will hear from the relevant doctors, who will have had to make a judgment on those things, but I do not think that the intent of the Bill is or should be that the panel simply confirms that the doctor has reached a judgment and then adopts that judgment. The panel should, of course, reach its own judgment. It is right that the panel will also hear from the person wishing to die and will make its assessment of them.

Particularly on the last matter—the absence of coercion or pressure—it may well be that highly relevant evidence will come from others. It may come from family, friends or others who know the person well, and we are familiar with a least one scenario where a new partner isolated the person in question before they suddenly and unexpectedly changed their view on their own assisted death.

The problem is that under the Bill as it stands it is very difficult, and perhaps impossible, for those who know the person seeking a certificate well to know that those proceedings are under way or in prospect. They may not know, and nobody has to tell them, that the person has made the relevant declarations, or even that they have an intention to die, or indeed that there is any reason to submit any evidence they may have.

I am not saying that every case in which someone has not told their family and friends of their decision to seek an assisted death will be concerning, but I think it is fair to say that a disproportionate number of the concerning cases will be in that category. In those cases, the panel may be making a judgment in the absence of relevant—perhaps crucial—evidence and they simply cannot do their job properly if that is so.

Catherine Atkinson (Derby North) (Lab): Is the right hon. and learned Member as concerned as I am that the panel does not even need to consider looking at evidence from family, friends, or those caring for or treating the person? Is he also concerned that although the panel might be required to hear from the person, that will only be in exceptional circumstances and there will be no requirement to ask any questions at all?

Sir Jeremy Wright: I understand the hon. Lady's point and I have seen her amendments on the subject, which are very sensible. We need to think about the way in which the panel process will actually unfold. If we believe that this is an important safeguard, as, I think, is a common view, we need to do everything we can to make sure that it is an effective one. Like the hon. Lady's amendments, my amendment 47 seeks to remedy the problem by ensuring that the assisted dying commissioner notifies anyone they think may have relevant evidence to give so that they can give it. That evidence may, of course, not change the panel's decision, but in some of the most troubling cases it will, and the opportunity for the panel to consider that evidence, when the stakes are so high, must surely be provided for.

I accept that what I am proposing is an infringement of the privacy of the person wishing to die—it is a fetter on their ability to choose to die without informing their family or friends as they may wish—but the Bill is all about balancing the rights of a person to die as they wish with, on the other hand, our duty to protect the vulnerable from abuse. That is exactly why the stages through which a person must go in order to be assisted to die are in this Bill, including obtaining the grant of a certificate from a panel. To be of value, as I say, that must surely add new protections to the other stages.

Sir John Hayes: We were assured that one of the key safeguards in the Bill's original incarnation was a legal test. That process—had it been retained, of course—would have enabled the collection of evidence in the very way that my right hon. and learned Friend is describing. It is partly because the safeguards have been weakened that we have the dilemma that his amendments seek to deal with.

Sir Jeremy Wright: I understand my right hon. Friend's point, but I am not sure I entirely agree with him. I think some of the procedural problems I am describing would have existed even with the previous iteration of the Bill, but certainly they are there in its current iteration. At this Report stage, I am seeking to fix the problem that arises from the difficulty for the three qualified individuals who will constitute these panels to express a considered judgment. If we are to have added value in the panel stage of this process, we surely have to enable the panel to make good judgments. Good judgments come from the capacity to assess all the relevant evidence. The Bill, as it stands, makes it very hard for the panel to have access to all that evidence in every case, but perhaps especially in those cases where the additional safeguard is most needed.

Robin Swann (South Antrim) (UUP): On the right hon. and learned Gentleman's point about the panel, the Royal College of Psychiatrists said in point 5 of its concerns:

> "It is not clear what a psychiatrist's role on a…panel would be".

Sir Jeremy Wright: The hon. Gentleman makes a fair point. I think we can expect that the psychiatrist on the panel will subject the requirement on mental capacity, in particular, to some considerable professional scrutiny, but nobody on the panel, whatever their professional competence may be, is capable of doing the job properly if they do not have access to the necessary evidence, so we must make sure they do.

The fact that the panel may sit in public is not a sufficient answer to the problem that I am raising. First, that is because there will be many panels considering many cases, and we cannot expect those who have evidence of coercion, for example, to watch the lists in case the person they know happens to appear in them—when, of course, they have no expectation that they will.

Secondly, the panel will not sit in public in every case. Paragraph 6 of schedule 2 says:

> "Panels are to determine referrals in public".

That is the clear presumption, and it is welcome, but paragraph 6(2) says:

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

I can see nothing in the Bill about any grounds on which the panel chair may refuse such a request, so it will occasionally, or perhaps often, be the case that the panel will sit in private, and no one will know what it is doing.

The next issue is the way a panel will go about making the judgments it needs to make, which brings me to amendment 48. As we all know, most judicial and quasi-judicial hearings in this country are conducted on an adversarial basis. That is, by the way, a reference not to the tone of proceedings but to the presentation of both sides of an argument so that the tribunal can reach the right conclusion. That is what our judges and lawyers are used to. That matters here because this quasi-judicial stage in the process of seeking assistance to die is being offered as important reassurance that things will be done safely, but that reassurance cannot be offered if panels are asked to adopt a process for which they are ill-equipped. That is not a criticism of those who will sit on the panels.

I accept that, under the Bill as it stands, a panel may hear from and question any other person beyond the person seeking the certificate and the relevant doctors, but as I have sought to address in amendment 47, as things stand those other persons will in all likelihood not know about the panel's proceedings and therefore will not come forward of their own initiative with the evidence. The panel would have to go out and find them, and how exactly is it to do that? How does the panel know who may have relevant evidence to give, and with what resources will it seek them out?

The position on what resources will be available more generally for the process under the Bill remains unclear, but the impact assessment suggests that panels will be expected to deal with two cases a day. That suggests that they will spend somewhere between three and four hours on each. That is not much latitude for further investigation.

Amendment 48 proposes that the commissioner should notify a designated authority—the Secretary of State can choose the appropriate one—of an application for a certificate. That authority would then supply to the panel an advocate with the responsibility to raise arguments against the grant of the certificate, which the panel would not otherwise hear. I think that is important, because it would ensure that there was another participant in the panel process who could at least help the panel by prompting consideration of concerns, reservations or grounds for further inquiry before decisions were made.

My amendment 49 is about what happens once a panel has reached its conclusion. Clause 16 provides for a person seeking a certificate to be able to ask for reconsideration of a panel's refusal to grant one, but of course the Bill currently provides no equivalent right to challenge the decision to someone who believes that a panel should not have granted a certificate. Anyone in that position would need to resort to judicial review, which is complex and expensive.

Madam Deputy Speaker (Caroline Nokes): May I gently suggest to the right hon. and learned Gentleman that he might be bringing his remarks to a close? There are many other Members who wish to contribute this afternoon.

Sir Jeremy Wright: I certainly am, Madam Deputy Speaker. I am doing my best, I hope as briefly as I can, to explain these technical amendments in a hugely important Bill, in a part of the Bill that the promoter has advocated for because she believes it is a safeguard. I think it is important, Madam Deputy Speaker, that we establish whether it is such a safeguard, and if it can be improved, how it can be improved—but I entirely take your strictures on board and I will come as quickly as I can to a conclusion.

This is not an equality of arms point—I accept that these are not opposing parties in the traditional sense—but it is really about the presentation of new evidence. Presumably the advice to someone whose application for a certificate has been refused and who has new evidence to present would be to reapply to the commissioner, but what is someone who has new evidence to challenge the basis for an existing certificate to do? Judicial review is no help. That is about the soundness of the decision already taken, which will be assessed using the evidence already presented to the panel that took the original decision.

12.15 pm

The obvious scenario here is where someone comes forward after the granting of a certificate, perhaps because they did not know of the previous proceedings, with pertinent evidence of coercion. There is currently no mechanism for that evidence to be considered. I am not suggesting that people should simply be able to delay the process without grounds; my amendment 49 suggests that the commissioner will need to screen all such applications to ensure there is an arguable case to be made.

I tabled my amendments because I believe it is important, on Report, to accept that the Bill may become law and to make it the best law we can make it. This particular phase of the process can only be a safeguard if we enable the panel to do its job properly. The Bill's provisions are currently defective in that respect and it is extraordinarily important that we make them effective in order for the panel to do its job properly.

Simon Hoare: On a point of order, Madam Deputy Speaker. I do not wish to be flippant or to test the patience of the House, but we have just heard an important speech from a former Attorney General on some key legal points. This is still a private Member's proposal. How can the promoter of the Bill, the hon. Member for Spen Valley (Kim Leadbeater), respond to whether to accept amendments to her proposed legislation if she is not in the Chamber to hear the arguments? Is it not a discourtesy to the House and those who have spent some considerable time working on amendments, on both sides of the argument, for her not to be here to hear what they are advocating?

Madam Deputy Speaker (Caroline Nokes): I thank the hon. Member for his point of order, but he will know that that is not a matter for the Chair.

[Madam Deputy Speaker]

I remind the House that although there is no formal time limit, many Members wish to contribute in this very important debate and it would be helpful if Members could keep their remarks to within the eight minutes that was suggested.

Kevin Bonavia (Stevenage) (Lab): On Second Reading, I voted in favour of the Bill, partly because I believed in the principle of it—I believe the right to choice, and in the right not to choose—and partly because I believed that we needed to have a way of checking somebody's clear intention. At the moment, horrible deaths are happening and there are no such checks in place, so I was keen to see how this House could come up with a system that, although it would not be perfect, would be better than the terrible status quo we have now.

At that stage, we had two checks by medical practitioners, and then a third layer: the involvement of a High Court judge. Although I was pleased with a third layer, I was not convinced that it was the right way to deal with the matter. I am therefore pleased that that the Bill Committee proposed a panel of experts to make those checks, and the right hon. and learned Member for Kenilworth and Southam (Sir Jeremy Wright) has rightly addressed some of those points.

For me, having that panel in place is very important, and it is our job to see how we can strengthen it, so I want to speak to amendments 78 and 79. Amendment 78 would improve this provision by ensuring that there is a unanimous decision in favour of a certificate of eligibility—abstentions would not apply. That is better than what was previously drafted and is certainly better than a High Court judge. Amendment 79 would require those reasons to be set out in writing. There will be scrutiny of those decisions and we do need to have the reasons properly set out.

I appreciate that all hon. Members in the Chamber, and all those who have taken part in this process, have approached it with the best of intentions. It is not easy—it is difficult—and we have constituents giving us examples from both sides. We are doing the best we can to alleviate people's suffering—that, I hope, is our common intention across the House.

Warinder Juss (Wolverhampton West) (Lab): Like my hon. Friend, I found the decision to vote for the Bill on Second Reading a difficult choice, as it was for many, but it was to improve the current situation and to have dignity in dying. Does he agree that we should not impose on the Bill significant restrictions that would render it ineffective if passed?

Kevin Bonavia: My hon. Friend is right to think about the impact of restrictions. Today we are all trying, in our different ways, to improve the Bill, whether we believe in it in principle or not. I believe that the amendments to which I am speaking would improve the Bill.

As we all think carefully about the different parts of the Bill, we should ask ourselves this question: would it make things better than the status quo? I believe that it would. I believe that there would be fewer horrible, painful deaths. The amendments help in that direction. I remain a supporter of the Bill, and ask other hon. Members to think carefully too.

Damian Hinds (East Hampshire) (Con): For reasons of timeliness, I will speak only to amendment 101, which relates to adults with Down syndrome or a learning disability, although the amendment is directly relevant to new clause 1, as the right hon. Member for Hackney North and Stoke Newington (Ms Abbott) spoke about. Amendment 101 would disallow medical practitioners from initiating a conversation about assisted dying with a person who has Down syndrome or a learning disability. I speak primarily from my experience, along with others, on the all-party parliamentary group on Down syndrome and what we have heard from members of that community: people with Down syndrome and their families, and professionals specialising in the condition.

Many strong and deeply heartfelt arguments have been put by colleagues, and indeed to all of us by constituents in favour of the Bill, including by families in the most difficult circumstances to imagine—actually, they are sometimes unimaginable circumstances. Nobody could question the conclusions they have come to individually as a result of their circumstances. Equally deeply held and heartfelt points are made to us by people from the other perspective, also informed by their sometimes unimaginable own or family circumstances.

Of the arguments put against the Bill, I am particularly drawn to those around coercion. However, it is important to remember that coercion is not entirely a black-and-white matter. At the sharpest end, there are cases where an individual will directly bring pressure to bear on another for their own ends, but there are many gradations below that, and pressure can be felt differently by different people. It may be felt especially by people who worry they are a burden on their family, on caregivers, on the national health service, or indeed more broadly on society. Once assisted dying is an available option, over and above the question of pressure from others, I worry about the effect of pressure from oneself.

The Bill stipulates in clause 36 that the Secretary of State will issue a code of practice to ensure that the practitioner establishes that there is a "clear and settled intention" for the person to end their own life, including assessing that that person has

"capacity to make such a decision".

That will have material challenges of its own. However, with regard to amendment 101, I am talking about the initiation, suggesting or raising of the matter specifically with an individual who has a learning disability or Down syndrome.

Sir John Hayes: The critical point about my right hon. Friend's amendment, and indeed about new clause 16, is that they would put that on the face of the Bill. He is right to say that codes of practice and statutory guidance can be of value, but it seems to me that what is on the face of the Bill will be of fundamental importance, particularly in respect of coercion.

Damian Hinds: My right hon. Friend is right, of course. When we in this House are told that there will be secondary legislation, guidance or a code of practice, we can only ever take that on trust, and this subject is of such moment that what is on the face of the Bill is that much more important. Given the scale of the decisions that people could make as a result of this legislation, it is right that an additional layer of caution should be applied by legislators.

Obviously, it is important not to generalise—every single person is an individual—but it is the case that people with Down syndrome often exhibit distinct social characteristics, including great sociability, empathy, and a strong desire to please others and seek positive social feedback, while also being particularly sensitive to criticism or perceived failure, which can compound issues around communication and comprehension. We do not need to define what can result as coercion to worry about what might happen in that context.

Amendment 101 and new clause 1 are about initiating a conversation and ensuring that there are additional safeguards, and I urge the House to apply caution that is commensurate with the gravity of the path that could be embarked upon.

Cat Eccles (Stourbridge) (Lab): I rise to speak against amendments 102, 80, 5 and 38, and new clauses 16 and 9. In my varied NHS career, I have seen all aspects of death and disease. As healthcare professionals, we commit first to do no harm. As medicine advances at breakneck speed, we are able to preserve life far beyond what could have been thought possible in the past. However, there have been many times when I have felt that preserving life can be harmful.

Life-prolonging treatments do not always improve quality of life, and patients suffer pain and discomfort, as well as mental distress. Friends and family have to watch their loved ones go through these difficult experiences, and I believe that patients should have a choice to end their life with dignity when faced with a terminal illness. The safeguards in the Bill have been significantly strengthened in Committee, so amendments seeking further to delay the process are simply unnecessary. In the oral evidence given by multiple experts, including Professor Chris Whitty, it was argued that we must be mindful not to overcomplicate the process to the point that no one can access an assisted death.

Amendment 80 seeks to impose an unnecessary restriction by requiring the terminal illness to cause

“severe pain and discomfort that cannot be reasonably relieved”

by palliative treatment. However, the Bill already requires that symptoms cannot be reasonably relieved, and it is important to remember that terminal illness is more than just pain alone.

Amendment 102 states that “remediable suicide risk factors” must be addressed before any preliminary discussion. Again, that is already covered in the Bill, with multiple checks on mental capacity and mental illness. Suicide risk is complex and fluid, and as I know from my own struggles, it is possible to feel suicidal but not want to die. This is another vague and unnecessary barrier without clear legal or clinical definition.

New clauses 9 and 16 and amendment 5 all seek to undermine multiple layers of assessment, independent oversight and professional accountability, where safeguards are already strong and multifaceted.

Amendment 38 calls for patients to qualify only if they have not refused further treatment or taken life-shortening steps. It is morally wrong to force anyone to accept medical treatment that they do not wish to have. The Bill is about choice and autonomy, and the amendment would undermine the freedom to make deeply personal decisions about one’s care. This is not a one-size-fits-all pathway, and there must always be a patient-centred approach.

12.30 pm

My constituent Mark shared the story of his sister, who sadly died from a rare form of terminal cancer two years ago. Despite receiving the very best palliative care, her pain could not be relieved and she begged her relatives to help her to end her life, which obviously they could not do. Harjean’s father suffered a long and painful death as his body gave way to the point that he could not even swallow. That was not how he would have chosen to end his days, and his family had to share his suffering, as there was no other option.

The current system is clearly inadequate, unsafe, and lacks any compassionate and dignified options for end-of-life patients. I do not consider assisted dying to be any alternative to end-of-life care, and I will continue to campaign for better funding and resources for palliative care hospices, as will many other Members. The two must go hand in hand.

Luke Taylor (Sutton and Cheam) (LD): Will the hon. Lady give way?

Cat Eccles: I will keep going, because of time.

Other countries that have implemented an assisted dying law have in turn increased funding and access to palliative care significantly, ensuring a fairer and more equitable range of options for patients. I believe that the safeguards in the Bill are more than adequate, and it is important to remember that doctors and healthcare professionals are constantly looking out for consent, competence and possible coercion in medical and social care settings.

Several hon. Members *rose*—

Cat Eccles: I am almost done, so I am going to keep going.

Around 20 people per day die in excruciating pain and discomfort in spite of the very best palliative care, and we as lawmakers owe it to those people and their families, and to the thousands more who will die in the meantime, to continue the debate towards reform.

Siân Berry (Brighton Pavilion) (Green): I will speak only briefly, as I spoke in favour of the Bill on Second Reading in November, my name is on it, and I have long supported the campaigns to change the law, including those of Dignity in Dying and Humanists UK, of which I declare I am a member and patron.

Since the vote on Second Reading, I have met and listened to a range of groups, professionals and individuals, mainly those who have concerns and those who want to see further changes made. In Brighton that has regularly included constituents at my surgery, as well as a group of leaders of local faith groups and charities who provide support to different vulnerable groups, including disabled people.

Today we are debating about half of the more than 100 proposed amendments, led by several tabled by the hon. Member for Spen Valley (Kim Leadbeater), who

[Siân Berry]

has set out so well how she put them together based on her own very detailed work with civil servants and her listening, including to opponents. I cannot commend her work and that of the Committee more.

The new amendments from the promoter of the Bill include welcome changes to transparency rules and how the processes and decisions made are reported and scrutinised. Other MPs have also tabled many carefully drafted and clear proposals. On eligibility, I continue to support people with slowly progressive neurological diseases, such as motor neurone disease, as reflected by my support for amendment 4, which I have signed and which was argued for so well by the hon. Member for Harrogate and Knaresborough (Tom Gordon).

I intend not to list lots of amendments, but to set out briefly the approach that I will take to those amendments being debated, before listening to the rest of the debate and then deciding how to vote, because I believe we must end up with the strongest, clearest and fairest process for making decisions, safeguarding against abuse, scrutinising the use of the policy after it becomes law, and providing the very best and most appropriate help to people who want this choice at the end of their lives.

I aim to back strongly the amendments that demand greater reporting and recording of decisions made and that demand transparency, including financial transparency, demographic data and other statistics from those who are supervising decisions and providing the new service, including the new supervising commissioner. The ability to monitor the implementation of this policy, ensure it is working as intended and detect any problems immediately is really important to me. I will also back changes in the process that ask for more training for those taking part in decisions and to ensure fair and effective communication throughout, including new language requirements

However, I am not currently aiming to support amendments that I think place undue, compulsory, additional burdens, hurdles, intrusions or demands on the people applying for permission to make this choice beyond what is in the Bill currently. On the basis of what I have heard, the experiences of many of my constituents and the statistics, the people asking for this choice will, by definition, be at the end of a horrible disease—often terminal cancer—which they will have fought, and fought with their doctors, for a long time. They will now be facing their final months in a situation of potentially huge suffering over which they have no control and that they fear greatly.

We must all remember that only dying people are eligible. In the vast majority of these cases, the person's eligibility, capacity and reasons will be more than clear to the decision makers. I believe we must enable those cases to be approved in a respectful, caring and compassionate way, and as swiftly as the current Bill process allows.

In other cases, where things are less clear, I agree: many more questions may need to be asked. I believe that the professionals currently tasked in this rigorous process under the Bill will be very well placed to judge when more information, consultation and investigation will be necessary. Under the current rules, along with the amendments and new clauses I support, they will also have to account very clearly for what they ask and what they decide under effective scrutiny.

I cannot, therefore, support proposed changes that would make every applicant subject to additional intrusive steps and interrogation, with somebody appointed to argue against them, extra processes or compulsory psychological investigation.

Graham Stuart (Beverley and Holderness) (Con): Will the hon. Lady give way?

Siân Berry: I am sorry, but I am on my last paragraph.

Those measures are effectively barriers to helping eligible people make their own choice for when and how to die at the end of all they have suffered.

I truly believe we must not make the process of gaining permission any harder or more traumatic than we need to. Although I am listening hard to the arguments made, quite a few of the amendments and new clauses cross that line. These momentous decisions about our deaths must be led by compassion, and must not be made to seem like yet another battle for people who have already given their all to staying alive.

Naz Shah: I thank Members for supporting amendments 14 and 38 in my name.

I acknowledge that the promoter of the Bill, my hon. Friend the Member for Spen Valley (Kim Leadbeater), has said that she is happy, as of this morning, to accept my amendment 14.

My hon. Friend has also indicated that there might be a need to change some of the wording, but until I see the wording of the new amendment and can scrutinise it, I cannot make an informed choice about accepting that. In addition, I was told this at only 9.30 am, on the Floor of the House. It was not discussed with me, and I am not sure whether the promoter has discussed it with Ministers. This very argument has been hashed out in Committee, where many of us spent weeks and weeks scrutinising line by line.

Indeed, the promoter tabled her own amendment 181 in Committee to strengthen clause 2. At that point, Ministers, outlining their neutrality, said that the amendments tabled, for which many colleagues had argued, were not, in the Government's opinion, workable. In the Government's opinion, what has now changed? Has an assessment been made by my hon. Friend or the Government that these amendments could now be accepted?

What this speaks to—I emphasise this to all Members listening and to the public at home—is a fundamentally flawed process. [HON. MEMBERS: "Hear, hear."] This is not how we make legislation. I take my responsibility extremely seriously, as I am sure everybody in this House does. This is literally a matter of life and death. If the Bill passes without these safeguards, there is no coming back from those decisions.

Daniel Francis: As my hon. Friend knows, having been on the Bill Committee with me, I had the same advice from Ministers: they disagreed with the wording of some of my amendments, yet they were accepted by the Bill's promoter and the Committee and are now in the wording of the Bill. The position of the promoter and the position put to this House will now be that those amendments are not in line with the Government's position. What is my hon. Friend's view on the fact that we will be asked to support that?

Naz Shah: My hon. Friend is absolutely right. That is the problem with this Bill, this process and what we are being told. We are being given things on the face of the Bill—

Kim Leadbeater: I thank my hon. Friend for her passionate contribution, but this is exactly how we make law. We take evidence and have discussions—*[Interruption.]*

Madam Deputy Speaker (Caroline Nokes): Order. May I respectfully remind hon. Members that on Report we debate the amendments to the Bill, not the process of how law is made?

12.45 pm

Naz Shah: Thank you very much, Madam Deputy Speaker.

My amendment 14 is very much about anorexia. It has been debated and hashed out time and again. I have come to the House today and been told, while sitting in my seat, that my hon. Friend the Member for Spen Valley is minded to accept the amendment without any discussion. I do not know what risk assessments or other assessments the Government have made, so how can I speak to that amendment when I do not have those details? I can say that Chelsea Roff, an expert on anorexia, gave evidence to the Committee. I can talk about how clinicians from every single major charity for eating disorders have made it clear that if this Bill goes through, it will not be fit for purpose and people will fall through that loophole. Without the information in front of me, however, I cannot speak to the amendment.

Dr Tidball: Will my hon. Friend give way?

Naz Shah: Sorry, I will make some progress.

Kim Leadbeater: Will my hon. Friend give way?

Naz Shah: I will make some progress. I sincerely appreciate the guidance from you, Madam Deputy Speaker, from Mr Speaker and from all across this House—the Clerks have been really helpful.

I come back to the amendments. In Oregon, in the States, 60 women were given assisted death. Every single one of them—100%—were told that they had the capacity. We have an issue in this country. Some 11 cases have gone to the Court of Protection, and my understanding is that nine of them have been told that they do not have the capacity, but doctors have been given permission not to continue to feed them. That is an issue for us; there is an issue of capacity.

There is a second issue in relation to amendment 38, which I will speak to. Even if my hon. Friend the Member for Spen Valley accepts my first amendment in its entirety, word for word, we do not close the loophole with amendment 38. What if we have somebody with diabetes? The hon. Member for South Northamptonshire (Sarah Bool) spoke very passionately about diabetes. I know the experience, because I was gestationally diabetic on three occasions and dependent on insulin, and I also appreciate the risk of being a pre-diabetic. If somebody decides not to take insulin and that they do not want to have dialysis, they would bring themselves within the scope of this Bill as it is written. That is a fact.

Contrary to the many people who have been on the radio and in other places saying, “The Bill excludes people’s mental health”, this Bill does not, as it is written, say that mental health is excluded. [HON. MEMBERS: “It does!”] It does not.

Dr Tidball: Will my hon. Friend give way?

Naz Shah: No, I will make progress. I am very conscious that lots of colleagues are here. I remember that we were all sitting here in November the first time that we debated this Bill; more than 100 Members did not get to speak in that debate, and many people might not get to speak today.

I feel really disheartened. As other Members who were on the Committee have pointed out, we have spent so much time rehashing these arguments. There were opportunities to fix this Bill rather than me and others having to put down amendments, taking up time and not giving those who would otherwise have spoken the opportunity to speak.

12.45 pm

To come back to my amendment—I have completely lost track of time, and I am sure that you, Madam Deputy Speaker, will be clear that I need to start finishing off, so I will come to a conclusion. I have spoken to parents. I have spoken to the parents of a girl who had T1DE, which is diabetes with complexities of anorexia. They came to Parliament and they said that when their daughter wanted to go to Dignitas, the law that helped them was the one that meant that it would have been illegal. That is the law we are trying to change today.

If the safeguards in the Bill fail even once, it will be a young woman like Jessica who dies. It will be parents like Lesley and Neal who lose a child. That is a terrible tragedy that no family should ever have to endure and no one in this House will be able to say truthfully that we did not know or did not see that coming. That is not compassion; it is abandonment. I will not be complicit in that and I hope the House will not be either. That is why we must act now. Amendments 14 and 38 each would close a different and dangerous loophole. One without the other is not enough. If we are serious about protecting vulnerable people, this House must support both amendments.

Madam Deputy Speaker (Caroline Nokes): Order. Members will be aware that there are still many who wish to contribute to the debate. May I ask that contributions are kept to five minutes?

Kit Malthouse (North West Hampshire) (Con): I am grateful to you for that guidance, Madam Deputy Speaker. I am also grateful to the promoter of the Bill, the hon. Member for Spen Valley (Kim Leadbeater), for putting me on the Bill Committee where, in my view, we did some excellent work. Although we have heard an awful lot of claims about the process, I think anybody objective who reads the Bill that is now being reported to the House will recognise that it is a strong piece of work that is measured and seeks to strike a balance in a difficult area of complexity, humanity, compassion and morality.

Before I discuss some of the amendments, I want to bring the House back to what we are trying to deal with: a set of people who have been told that their struggle with disease is over, that they are heading towards an inevitable death and that there is nothing more that medical science can do for them. What we are trying to do is to give them the chance to face death on their own terms. That is the simple mission that the House has been set.

The second thing I want Members to contemplate as they look at this slew of amendments is that although it is easy to look at each amendment individually and see its merits or demerits, we must bear in mind the machine we are building as a whole, and the fact that we are putting those people through this process at a time when they are facing the end of that struggle. They are thinking about what the nature of their death will be like and they are talking to their friends and family, putting their affairs in order, and being concerned about when that awful day is going to come. We have to have some compassion in the process as well as compassion in the purpose.

When Members consider some of the amendments I will highlight, I ask them please to keep in mind that we will have to put these people through a possible two-month process at a moment when their time is severely limited, very often to less than six months. For example, new clause 7 and amendment 50, tabled by my hon. Friend the Member for Meriden and Solihull East (Saqib Bhatti), would restrict the number of patients that doctors can deal with in any 12-month period. That will severely restrict access and may mean that patients who are partway through the process have to change suddenly because their doctor is time limited, pushing them out, notwithstanding the multiple safeguards we already have in the process.

My right hon. and learned Friend the Member for Kenilworth and Southam (Sir Jeremy Wright) gave an interesting speech about amendment 47. Again, in that amendment, he would be creating another step, another delay and another set of problems for the dying person to overcome or issues for them to address. In his amendment—I am sure he is a much better lawyer than me—I found it odd that he would effectively be creating an inexhaustive list of individuals who could be called upon in any circumstances who might be "properly interested" in the welfare of that individual. To me, the person who should be the most interested in their future is the person themselves. Any step we take that cuts across their privacy, their autonomy and the alacrity with which they can seek this solution to their impending or perceived agony seems a step too far. I do not understand how, practically, the commission is supposed to ascertain who those individuals are—are they neighbours, friends or just family? What is the definition of family? We need to put that contemplation and how they want to handle their death squarely in the hands of the dying person.

Jess Asato: The right hon. Member mentioned that the person is autonomous and should be protected from inquiries about them, but what if they are not autonomous because they are being coercively controlled by a partner? What if that partner has prevented them from reaching out to their family to let them know that they are going to take an assisted death? Would it not be a great safeguard to ensure that the panel and all the doctors around them had ascertained that the family had been told?

Kit Malthouse: The hon. Lady makes a good point, and it was a compelling point made in Committee and is certainly one that we recognise. That is why the amendments on training that she tabled in Committee were adopted—specifically to ensure that everybody involved in the process is sensitised to detecting those issues and to make clear that any doctor in the process, and indeed the panel, might want to know why family are not being informed. That is specifically why a social worker was put on the panel: to understand the psychosocial environment in which the person is taking that decision. Fundamentally, in the end, if I am facing my death in a matter of weeks and decide in my capacity that I do not want to inform my family, that is my choice. That is my decision. I may have to explain my reasons to the doctors, but—

Madam Deputy Speaker (Caroline Nokes): Order. On that point, I remind Members that we are very short of time.

Kit Malthouse: I am grateful, Madam Deputy Speaker; I will be swift.

That is my choice, and this Bill is rooted in the need to give autonomy to those facing death who have capacity. We should take care to tread carefully upon that right.

On the two amendments tabled by my hon. Friend the Member for Reigate (Rebecca Paul), new clause 16 says that somebody cannot be "substantially motivated" by certain considerations. I do not really understand what "substantially motivated" is meant to mean. To me, this misunderstands the complexity of what it must be like to be told that you are dying. The things that might run through your head—the affairs you might have to deal with, the news you have to break to your family, the impact it will have on your small children—form a cocktail of motivations. But the one thing I have learned over the last 10 years from campaigning for and spending lots of time with dying and bereaved people is that towards the end of their life, they have absolute clarity about what they want, because it becomes clear to them towards the end what their death will be like. At the very least, they want to have this card in their back pocket to play if they require it. Remember: these are people who are facing death, who are struggling with death, and we have to give them the power to advance over it.

Melanie Ward: Will the right hon. Member give way?

Kit Malthouse: Sorry, but I am conscious of time.

Finally, amendment (a) to new clause 10, which we might divide on this afternoon, is difficult. We debated a similar amendment in Committee. As sponsors of the Bill, we are clear that there should be a conscientious objection clause to allow individuals to opt out, and that is strengthened by new clause 10. But allowing an employer—any employer—to say that any employee in their employment cannot participate if that is what they decide seems to me a step too far, and it could prove to have unintended consequences. First, the board of every healthcare trust in the country will become a battle for control between those who oppose and those who do not. As my right hon. Friend the Member for Gainsborough (Sir Edward Leigh) said, people may suddenly find that they have to uproot themselves, after years of living in a care home, and relocate to get the kind of death that they want. In effect, the amendment prioritises the rights of somebody who is providing accommodation over the rights of the dying. As I said on Second Reading, in my view, as they face their end, we should prioritise the rights of the dying.

Madam Deputy Speaker (Caroline Nokes): It would be unprecedented to put a formal time limit on speeches. Please can Members listen to the stricture that we are very short on time? I call Lizzi Collinge.

Lizzi Collinge (Morecambe and Lunesdale) (Lab): Thank you, Madam Deputy Speaker; I had intended to speak about new clauses 1 and 10, but I will restrict myself to new clause 1 for the sake of time. New clause 1 says:

> "No health professional shall raise assisted dying…unless that person has first raised it."

If the patient does not mention the issue and specifically ask for it, the doctor would be entirely prohibited from even mentioning it. That is problematic for many reasons. It goes against good medical practice, and is actively opposed by the British Medical Association. For me, the new clause would undermine the hard-won rights of people to be fully informed of their medical options, and would make the application of the Bill unfair and unequal, to the detriment of marginalised people in particular.

Josh Fenton-Glynn (Calder Valley) (Lab): Just this week, the Health and Social Care Committee heard from vulnerable service-users who talked about white coat syndrome—that people are more likely to be pushed into options when given them by medical professionals. That is the concern behind the amendment. I do not know how I will vote on the Bill, but I am minded to support the amendment because of what I have heard from people from vulnerable communities.

Madam Deputy Speaker (Caroline Nokes): Order. Interventions also need to be brief.

Lizzi Collinge: I thank my hon. Friend for his intervention. I will expand on this, but that is exactly why good medical practice requires all options to be on the table. Patients should not be influenced by the opinions, whether philosophical or medical, of a doctor; they should be able to give full and informed consent. I believe that new clause 1 would chill those discussions, and limit the option of an assisted death to those already in the know, those who are the most medically literate, and those who are often the least marginalised in society. It would result in unequal access to a legal process, and flies in the face of good medical practice, which has moved away from the paternalism that harmed patients and took away their individual control. After many years of fighting, mainly by women and marginalised communities, it is now established that good healthcare practice means patients having full information to make their own decisions.

Tom Collins (Worcester) (Lab): Will my hon. Friend give way?

Lizzi Collinge: I am mindful of time, so I will continue.

Why, then, would we now choose, as a House, to hide from patients information about their options? For so many years, people have been put through that. Informed consent to treatment, including end of life care, is informed only when it includes all options. There is also the practical element of what would count as a patient raising it first. Would they have to make a specific statement? Would they have to use specific language? It would create a legal and medical minefield for doctors and patients.

Sarah Russell (Congleton) (Lab): Will my hon. Friend give way?

Lizzi Collinge: I am very mindful of time, so I will finish with this point. Colleagues may wish to look at the NHS constitution, which says:

> "You have the right to be involved in planning and making decisions about your health and care with your care provider or providers, including your end of life care, and to be given information and support to enable you to do this."

That can be the case only if people are given the full information. All people should have access to full information on matters of care. To do otherwise is to deny people their decision—it is paternalistic, and we should move away from that model. People have fought so hard for that to happen.

We have a chance today, colleagues, to ensure that the legislation is the best it can be. It has been a pleasure to listen to the contributions of colleagues across the Chamber. I am minded to support the amended Bill on Third Reading, because the current situation for terminally ill people, with no safeguards, no protection and no choice, is absolutely unsupportable.

1 pm

Dr Ben Spencer (Runnymede and Weybridge) (Con): I rise to speak to amendments 18, 30, 31, 17 and 32, which stand in my name.

I will start with amendment 18. Many moral arguments on the need for the Bill have been proposed both inside and outside this place. Some of those arguments have addressed the desire for greater control at the end of life, but the vast majority have focused on the prevention of irreversible suffering. The principle of bodily autonomy—which I strongly support in the context of full decision-making capacity, with certain important caveats—is used to justify the rights that the Bill will grant. However, let us put aside the debate surrounding the Bill and focus on the text of the clauses, which is the task that we face on Report.

The provisions are silent on suffering, silent on control and silent on all but a terminal illness with a prognosis of fewer than six months. If the principle is that we must prevent irreversible suffering, all those suffering irreversibly should be able to seek physician-assisted suicide. If the principle is that we should give people control—another level of expression of bodily autonomy—all adults who truly and freely consent with full decision-making capacity should be able to seek physician-assisted suicide. If those principles are circumscribed to an

[Dr Ben Spencer]

arbitrary definition of "terminal illness", the inexorable conclusion must be that those patients' suffering or autonomy are more important than those of others, or that their lives have less value. We have seen that position subtly imported into this debate. When requesting an assisted death is not framed as suicide because some perceive it as understandable, the underlying argument is, "If you're terminally ill, of course you want to die—that's understandable."

We must ensure that we do not, by accident or otherwise, enshrine in our statute book value judgments on the worth of the lives of the terminally ill or on the protections that they should enjoy like everyone else. I tabled amendment 18 to expand the scope of the Bill as much as I can to reduce the discrimination inherent within it. The maximum I could do was to remove the six-month restriction, but I wish the amendment could go further. I know that some Members will wince at this provision, but I ask them to ask themselves what the principles and values in the Bill are, how they are being applied and whether they are being applied equally. I believe that the Bill as drafted is incoherent and discriminatory. My amendment would introduce some moral clarity to the Bill. If we do not do so, the courts will.

I turn to amendments 30 and 31. If we are to rely on the principle of autonomy to authorise physician-assisted suicide for terminal illness, the expressed choice must be true and free. Autonomy needs help, though. A true and free choice needs to be informed; a true and free choice cannot be made under coercion; a true and free choice requires decision-making capacity. I believe that, if we are to rely on the principle of autonomy for the most grave of decisions, there needs to actually be a choice. In the absence of relevant and available palliative care options, where is the choice? How can we rely on autonomy in the absence of choice? The prospect of people choosing physician-assisted suicide not because it meets their needs, but because their needs are unmet owing to a failure in the provision of palliative care, is a moral outrage. My amendments 30 and 31 would ensure that that does not happen.

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

Dr Spencer: I am sorry but I really cannot, given the time restrictions.

Amendment 17 pertains to the test of decision-making capacity. In English and Welsh law, we use the Mental Capacity Act 2005 to define capacity, and I believe it is right that the functional test of capacity is used in this Bill. We have common law tests of capacity in some circumstances, which arose before we had the Mental Capacity Act. However, the decision to end one's own life was not permitted in the early case law leading up to that Act. There is no jurisprudence background or guidance. These capacity tests have not been done before. This test needs a bit more of a framework of support.

Amendment 17 lays out the minimum information that needs to be understood as part of the functional test of capacity. Critically, that would include information about the current treatment options, about doing nothing and about proceeding under this legislation. It would make clear that physician-assisted suicide is not a medical treatment, but a personal choice about life and death. Without amendment 17, this Bill will fundamentally undermine the doctor-patient relationship. Doctors do not prescribe death, and this Bill must make that clear.

I turn finally to my amendment 32. There has been some discussion about the inadequacies of the decision-making capacity test as gatekeeper. In effect, there may be circumstances in which, despite having capacity, the person is otherwise recognised as vulnerable. That is how our courts operate. The impact of depression or personality disorder on decision-making capacity can be subtle and elusive. I know, as I used to be a consultant liaison psychiatrist and did research in the area of decision-making capacity. This is tricky stuff to do, especially in the context of a request for an intervention, rather than a refusal.

We should have trained psychiatrists at an early stage assessing capacity. They are expert at picking up these subtle cues and all the other stuff that is going on. A request for physician-assisted suicide should not be taken in isolation, and that needs to be understood and supported. We need someone who knows how to use the Mental Health Act, because if a doctor is doing the assessment, and they have a patient in front of them with a mental disorder, expressing a desire to end their life, they need to make sure that that patient gets the right and appropriate treatment. That may well be using the Mental Health Act. We need to make sure that this happens; I hope it would happen as part of the process as usual, but there is no safeguard in the Bill to make sure that it does. Psychiatrists turning up on the panel at the end is not good enough; they need to be there from the start.

Finally, there are broader issues about the interaction with protections to save life, article 2, and a doctor's duties. I will cover those in the debate on the second grouping, along with the incredible importance of the Bill's interaction with the suicide prevention strategy.

Daniel Francis: I rise to speak to amendment 24 in my name, and I will start by thanking my hon. Friend the Member for Spen Valley (Kim Leadbeater) for inviting me to be a member of the Bill Committee.

I accept the principle that somebody given the devastating news that they have six months left to live should be able to choose the moment that they die, with their loved ones around them, but this is not a vote on the principle. We are not being asked to make an arbitrary yes or no choice, for we are legislators, and my experience on the Bill Committee tells me that this Bill, as written, still requires additional safeguards to address the concerns of so many people in this country.

For me, it was death, and my thoughts and concerns about what happens when I die, that drew me to my conclusions on this matter.

Gregory Stafford: Will the hon. Gentleman give way?

Daniel Francis: I will not, because of time constraints; I am sorry.

Like a small number of other Members in this House, I know the daily concerns of being a parent of a child with complex disabilities, including a learning disability. That concern lives with you every single day of your life: that concern about what will happen to your child when you are gone—about who will assist your child, because of the help they require due to their level of mental capacity and the difficulties they have communicating and interpreting information. The concern that haunts me every single day is, "Who will make, and how will they make, those decisions to support my daughter when my wife and I are gone?"

That concern, shared by thousands of others, led me to the conclusion that the Mental Capacity Act 2005 was not written for this scenario. The parents of someone with a learning disability become accustomed to supporting them in their decision making. We understand their sight and communication difficulties, and the language needed to help them make a decision. The Mental Capacity Act rightly has a low bar to allow individuals to live a fulfilling life, because we would not want individuals to have their capacity assessed to purchase a coffee or withdraw money from the bank.

I raised countless times in Committee—it was never challenged; in fact, it was accepted in some exchanges—that it would absolutely be possible for the following scenario to occur. An adult with a learning disability discovers that they have less than six months to live. They have a level of mental capacity that allows them to make many decisions in life. They have enough capacity to understand that they could be a burden on their elderly parents. Their elderly parents might take the view that their son or daughter requires support to make the most complex decisions, yet because their son or daughter is assumed to have capacity under the first principle of the Mental Capacity Act, they could go through the entirety of this process—and the first time that the parents were aware of it would be when they were informed that their child had been assisted to die.

For the same reason, I support amendment 8, tabled by my hon. Friend the Member for Derby North (Catherine Atkinson), and amendments 10 and 33, tabled by my hon. Friend the Member for Lowestoft (Jess Asato), which relate to family members' awareness of the process.

The second principle of the Mental Capacity Act is:

> "A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success."

It was accepted in Committee that doctors would have to assist individuals in this scenario to make the decision about an assisted death. From my lived experience, I would query how some aspects of the Mental Capacity Act are being carried out, given that I often have to deal with professionals who deem that my daughter has less or more capacity than she actually does. I have accepted that she would not have enough capacity to go through the process, but the Bill Committee heard from Mencap in oral evidence that the vast majority of people with a learning disability in this country are not in the same position and could apply for an assisted death.

The Bill Committee heard from many people. Dr Rachel Clarke raised her concerns about capacity. Baroness Falkner, giving evidence on behalf of the Equality and Human Rights Commission, said that

> "capacity is a very serious consideration in our concern."—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee,* 29 January 2025; c. 178, Q232.]

Dr Jamilla Hussain gave evidence about one palliative care team deeming that someone had capacity, while another palliative care team deemed that they did not. We heard from Professor Gareth Owen, from Dr Annabel Price and from Dan Scorer of Mencap, who all raised concerns.

In the last week, the Law Society has said that Parliament should fully consider how the Mental Capacity Act would operate under the Bill before any legislation is passed. The Royal College of Psychiatrists has said that although it is neutral on the issue, it opposes the Bill as it stands—particularly the mental capacity aspect, because, as it is written, it does not correlate with the Mental Health Act. Over the last few days, the Royal College of Physicians has also come out in support of that position.

Over the last six months, I have heard a lot about choice, compassion and dignity, but what about choice, compassion and dignity for the people I have described? I fundamentally believe that it is my job, and the job of all of us, to protect the most vulnerable—but the Bill, as it stands, fails to do that. I have every sympathy with somebody at the end of their life, as I have said; I believe that they should have the right to go on their own terms, at their own time. But are there sufficient safeguards to ensure—in response to those who have links to the press and Parliament to make their voice heard—that we fully consider every scenario and safeguard those who do not have those links and who do not have a voice?

If that choice comes at the price of one person, in a borderline capacity decision, being presumed to have capacity, that will be one death too many. My view is that it is not a price worth paying to allow others to have that choice. For that reason, I implore colleagues to support my amendment 24.

Several hon. Members *rose*—

Madam Deputy Speaker (Caroline Nokes): Order. I urge the few remaining Members who will get in to keep their remarks brief, please.

Carla Lockhart (Upper Bann) (DUP): As I thought about today's debate, I asked myself, "What more can I say than I said in the previous debate?" Yet there is much more, because as the Bill made progress through Committee, its intentions were exposed over and over again. Commitments, safeguards and kind words championed in this place have been set aside. On Second Reading, we were told that the Committee considering the Bill would be balanced and representative, yet its make-up did not reflect that intention: 55% of MPs voted for the Bill on Second Reading, but 61% of the Committee supported it.

The mask has slipped time and again. One of the biggest blows to the Bill, which the public listening today need to know about, relates to the need for approval via High Court judges. On Second Reading, that was laboured as the strongest safeguard, but that safeguard has been removed at a stroke. What is now being legislated for is a panel of psychiatrists—and a voluntary panel, at that. Impartial judges have been replaced by a voluntary panel, which could well be made up of enthusiasts for assisted dying, and the Royal College of Psychiatrists has now said that there are not even sufficient psychiatrists for such panels.

I want to be absolutely clear: this Bill is immoral. If it is passed at a future date, it will create a publicly funded, gold-plated assisted suicide service. That means that the state will have the ability to give a legal drug to

[Carla Lockhart]

end a life. It is immoral, and it goes against my strong Christian faith, and that of many of my constituents in Upper Bann and people across the United Kingdom.

1.15 pm

Although I note that the intention behind new clause 10 is to increase the conscience protections in the Bill for the many healthcare professionals who will wish to play no part in assisting the premature death of a patient, it does not go nearly far enough in upholding the long-standing commitment to freedom of conscience in our country. Members across the House have regularly remarked that this is a conscience vote for many parties and that we must respect one another's views, but if we are committed to allowing conscience in this place, we must also protect it outside this House.

I am deeply concerned that new clause 10, which the hon. Member for Spen Valley (Kim Leadbeater) has portrayed as a safeguard, does not replace or disapply amendment 341, passed in Committee, which, while removing the duty of referral for healthcare professionals, still requires them to point people in the direction of where they can "obtain" information and have a "preliminary discussion" about assisted suicide. Indeed, the new clause not only does not repeal that requirement; it reinforces it.

Paula Barker: Will the hon. Lady give way?

Carla Lockhart: No, I will not give way because of time.

The new clause would not affect any duty relating to a requirement to provide information. That concern over conscience was raised earlier this week by the Royal College of Psychiatrists in its press release, which announced its opposition to the Bill and set out its concerns that clinicians are still required to signpost patients to information on assisted suicide. It noted:

> "For some psychiatrists who wish to conscientiously object, this would constitute being involved"

in the assisted suicide process. New clause 10 will not allay such concerns. When those representing clinicians express such concerns, we ought to listen to them—listen to the professionals. I encourage Members to listen to the royal college and the 250 GPs opposed to the Bill.

Turning to amendment 101, I have a word for our Down's syndrome community. In a statement published on 9 May, the Down's Syndrome Research Foundation said:

> "We are deeply concerned about the risks of coercion and undue influence. In particular, people with Down's syndrome and intellectual disabilities are at significant risk of coercion and undue influence, in part because of their need to trust and rely upon caregivers and medical professionals."

I cannot comprehend why the hon. Member for Spen Valley declined to accept an amendment in Committee that would have provided explicit protections for people with Down's syndrome. Again, that highlights the flaws and the risk of coercion. The reality is that vulnerable people who are more prone to coercion—for example, people with learning difficulties or a history of depression—have not been explicitly protected in the Bill.

This Bill is not safe and cannot be fixed. It is weaker than it was before the Committee began, and I encourage all concerned Members to recognise that it is flawed and that no amendments or tightening up will ever make it right to legislate to end one's life with a legal drug.

Dame Meg Hillier: On a point of order, Madam Deputy Speaker. Many people have put in to speak today, and we appreciate the huge challenge to you, chairing this debate, and for the Speaker's Office. It is normal for private Members' Bills that the debate continues in an orderly and proper fashion so that everyone can have their say. We appreciate that that is much more challenging in these circumstances, but we have heard many times that we are running out of time, Members are not taking interventions because of concerns about time, and the informal time limit has dropped to five minutes. I am aware that the Front Benchers still need to speak. It is in the power of the Chair, of course, to refuse any suggestion of a closure motion. I would like to ask you whether there is any thinking going on about whether this debate can continue. Many of those who have tabled amendments have not yet been called to speak, and I, for one, would like to hear their points of view.

Madam Deputy Speaker (Caroline Nokes): I thank the hon. Lady for her point of order. She would not wish me to anticipate any decision on a closure motion at the current time, I hope. She makes a valid point that many Members who wish to speak this afternoon will be disappointed, but she will also know that there will be further debate on the second group of amendments.

Dame Meg Hillier: Further to that point of order, Madam Deputy Speaker. My concern is that this is the last debate on these amendments. It is in the control of the Chair whether to grant a vote on a closure motion. I simply make that point, as I am sure you heard, Madam Deputy Speaker.

Madam Deputy Speaker: I reassure the hon. Lady that I have heard her point. I repeat that I will not make a pre-decision on any closure motion that has not yet been moved.

Dr Opher: I will be very quick, Madam Deputy Speaker, because I am aware of the need to fit in as many people as possible.

I will address a few issues on the assessment of capacity under new clause 9. One key point about assessing capacity as a doctor is that in most cases it is very clear cut: someone either has capacity or they do not. That is quite easy and quick to establish. With a very small number of patients, it is more difficult. By amendment to the Bill made in Committee, we must now refer such a person to a consultant psychiatrist for an assessment by a specialist. They are then in the best position to assess those very difficult points of capacity. That very much strengthens the Bill.

I will speak very briefly to new clause 1. As doctors, we must, under our ethical obligations, give options to patients. If we are absolutely forbidden to do that—new clause 1 would make it a crime, so we could be convicted for doing so—that totally wrecks the doctor-patient relationship. It is unprecedented and unworkable.

Several hon. Members *rose*—

Dr Opher: I am sorry, I cannot give way. I am just going to go through these points very quickly.

That is why the BMA is against new clause 1. There is no duty for doctors to raise the issue, but there should not be any ban on them doing so. As I have pointed out, the so-called gagging clause was introduced in Victoria as part of the legislation. However, after five years that has now been removed by an independent review, because it caused confusion and it harmed patient care. I urge colleagues to vote against new clause 1. Let us respect the patient's right to information, not restrict it. Let us ensure that no patient is left suffering simply because they did not know what to ask, and that no doctor is punished for trying to help.

Sarah Russell: I thank my hon. Friend for giving way. On that point, I have particular concerns—

Madam Deputy Speaker (Caroline Nokes): Order. May I just clarify whether the hon. Gentleman was giving way?

Dr Opher: Yes, I am happy to give way.

Sarah Russell: Thank you, Madam Deputy Speaker. On that point, does my hon. Friend agree with my concerns about new clause 2, which, although genuinely meant and intended, is in danger of being read, together with new clause 1, to indicate that it should not be discussed with children at all, even if they raised it first, because of the difference between the wording of the two clauses?

Dr Opher: Any restrictions around the doctor-patient relationship will harm patients, so I agree with my hon. Friend.

Sarah Olney (Richmond Park) (LD): I rise to speak in support of amendment 87, which stands in my name, and in support of various amendments tabled by other Members and also signed by me.

Prior to this legislation being laid before the House, I had not held strong feelings about the issue of assisted dying. I listened carefully to the arguments on both sides, including those of the many constituents who wrote to me on the issue, before deciding to vote against the Bill on Second Reading. I made my mind up very late in the day. I continue to be appreciative and respectful of the reasons why people are in favour, but, for me, the fundamental question was whether we were putting vulnerable people at risk by passing this legislation. I resolved that, on balance, we were.

The lead Member, the hon. Member for Spen Valley (Kim Leadbeater), was keen to reflect the balance of opinion across the House, as well as within parties, in the make-up of the Bill Committee, and I was happy to volunteer as the sole Liberal Democrat "no" voter, as a service to my party and to the House. It was a privilege to serve on the Committee, and I wish to put on the record my admiration and respect to all Members, Ministers, Chairs and House staff who served alongside me, and my thanks to the many witnesses who gave oral and written evidence on which we came to rely.

I regret to say, however, that my experience in Committee has only hardened my opposition to the Bill. My opposition is not rooted in a fundamental objection to the principle of assisted dying, but in the approach taken to framing the legislation.

Amendment 87 seeks to tighten up the arrangement around the first declaration, to rule out the possibility of "doctor shopping". In oral evidence we heard from the chief medical officer, Professor Sir Chris Whitty, that a diagnosis of terminal illness and a prognosis of life expectancy cannot always be made with a high degree of accuracy and that a degree of professional judgment is required on behalf of the co-ordinating doctor, which can result in differences of diagnosis and prognosis.

That was backed up by the Royal College of Physicians this week, whose spokesperson was quoted in *The Times* saying that it is "extremely hard to tell" if somebody has only six months left to live. My amendment seeks to establish whether the patient has already sought and been refused permission to seek an assisted death so that the co-ordinating doctor can consider the reasons for the first refusal and whether the patient's circumstances have materially changed since that time.

Neil O'Brien: Will the hon. Member give way?

Sarah Olney: I will not; I am sorry.

The amendment would help to inform the clinical judgment that will need to be made in each individual case and discourage patients from applying to multiple doctors for an assessment.

I am proud to support amendment 24, tabled by the hon. Member for Bexleyheath and Crayford (Daniel Francis), which would disapply the presumption in the Mental Capacity Act 2005 that a person has capacity unless the opposite is established. There was a great deal of debate in Committee about the efficacy of the Mental Capacity Act and whether its provisions were sufficient to establish an individual's capacity to make an informed decision about whether to seek an assisted death. The hon. Member for Bexleyheath and Crayford spoke compellingly in Committee about his experiences of how the Act is not always applied effectively. I am glad that the whole House has had an opportunity to hear him today.

The Royal College of Psychiatrists cited the insufficiency of the Mental Capacity Act as one of its nine reasons for opposing the Bill earlier in the week. It said:

> "The Mental Capacity Act was created to safeguard and support people who do not have the capacity to make decisions about their care or treatment or matters like finances. Should the Bill become law in England and Wales, implications for both the Mental Capacity Act and Mental Health Act need to be considered."

I also support new clauses 1 and 2, tabled by the hon. Member for Hackney South and Shoreditch (Dame Meg Hillier), which would prohibit health professionals from raising the subject of assisted dying with a patient. It is my personal belief that people's rights to pain relief and palliative care towards a natural end should be prioritised above an assisted dying pathway, and that that should be made available only as the result of a specific request. It is particularly important that young people under the age of 18 should not be thinking about assisted dying as an alternative to continued treatment or palliative care.

I was disappointed that during Committee my proposed amendments to safeguard people suffering from eating disorders were rejected. Eating disorders are primarily a mental health condition but have an obvious physical impact, and there is a severe risk that the physical

[Sarah Olney]

impact of an eating disorder can be diagnosed as a terminal illness, when in fact eating disorders are always treatable. We cannot allow vulnerable sufferers from eating disorders to elect for an assisted death when there remains the possibility of a full recovery and the chance of a happy and fulfilling future. That is why I support amendment 14, in the name of the hon. Member for Bradford West (Naz Shah), who was such an articulate member of the Bill Committee. I was glad to hear that the lead Member, the hon. Member for Spen Valley, will adopt that amendment; I look forward to seeing the further drafting.

I also support amendment 16, tabled by the hon. Member for Vauxhall and Camberwell Green (Florence Eshalomi). I welcome the lead Member's new clause 10, which extends the right to refuse to participate in assisted dying to any person, but it is important also to extend that right to organisations such as hospices and care homes. Assisted dying undermines those institutions' mission and purpose, and they should have the right to refuse to provide it on their premises if they do not wish to participate in it.

Finally, I will speak in favour of amendment 22, tabled by the name of the hon. Member for Shipley (Anna Dixon). There is insufficient provision in the legislation to identify and seek to ameliorate mental health conditions or other factors that may lead people to seek a premature end to their life, which they would not seek if those factors were addressed. Every time a person seeks to end their life prematurely is deeply regrettable, and we have a duty to explore whether preventable factors could be addressed before a request for assisted dying is granted.

Dr Kieran Mullan (Bexhill and Battle) (Con): As has been the case throughout the Bill's consideration, His Majesty's Opposition have not taken a position on the principle of the Bill, and nor do we take a position on any of the amendments before the House. It is not for me to justify or argue against particular amendments. The arguments for and against have been well ventilated by hon. Members today.

As we might expect—I know this from my own email inbox—many constituents are considerably more interested in our proceedings than might ordinarily be the case for a Bill's Report. It might also be the case that there is not a complete understanding of the nature of today's proceedings, so I hope that I might usefully reiterate what we are and are not doing.

I then want to make some remarks focused on the public and campaigners, about how they should reflect carefully on their own obligations to respect the sincerity and freedom of choice of Members. I have come to consider that issue to be important, given some public interventions by high-profile campaigners, experiences with my own constituents and experiences that I know other hon. Members have had when they have been lobbied on the topic and on the way in which they will be voting today.

1.30 pm

On our proceedings, it needs to be said that some members of the public will have assumed that the matter of assisted dying had been settled on the back of the widespread reporting of the vote on Second Reading. It was not always clear in all the coverage that the vote on Second Reading was essentially on the principle of assisted dying, and that the form the legislation might take could still change or potentially it may not even be passed at all. The size of the majority secured by those in favour has led some commentators to claim that it will definitely be passed in some form. That is certainly understandable, but we should not take that outcome for granted, not least because that would be a disservice to the very important work of the Committee over recent months and what may happen on Report, all of which could change Members' decisions in both directions.

So that the public understand, let me set out that since the Bill was voted for on Second Reading, a small number of MPs have gone through it in considerable detail. I am sure that each and every one of the Committee members will have felt the weight of responsibility when considering such a sensitive and important matter. They spent many long hours considering and debating exactly how assisted dying should work in practice. I know the whole House will join me in thanking them for their efforts.

The public should understand that today, similarly, all MPs collectively will be deciding what further changes, if any, should be made, but we are not voting on whether we will, in fact, introduce assisted dying. Some of the public think that today is another matter of "yes or no", but it is not. Instead, we are beginning the process of deciding the final form in which assisted dying will be put before the House and potentially passed into law.

The Committee considered over 500 amendments to the Bill during line-by-line scrutiny, and approximately one third were agreed to. Those two numbers alone—the number of amendments made and rejected—indicate how detailed and challenging is the process facing the whole House. We cannot escape the very high levels of contention to each and every aspect of the Bill—even whether we should refer to "assisted dying" or "assisted suicide" has been subject to debate. As much as it might be of wider interest to the public, given its greater visibility now that the Bill is again being debated on the Floor of the House, as Mr Speaker indicated at the start of the debate, now is not the time to go into all the changes that have been made. Those interested can refer to the helpful briefing notes produced by the House of Commons Library.

Even with the very many changes made to the Bill in Committee, today we have been debating further changes. We have focused on the amendments relating to the obligations, duties and protections for medical practitioners, hospices and care homes.

Jess Asato: The shadow Minister says that we are debating those amendments today, but we have not actually been able to hear from all those who have tabled those amendments. Nine Members who have tabled amendments have not been called to speak, so how can we call this a debate when we have not even heard why they are proposing their amendments in the first place?

Dr Mullan: I will make some remarks about the process. The time allocated today is a matter for the Chair and it would not be appropriate for me to comment, but I accept and understand the concerns raised by the hon. Lady and other hon. Members.

Today we have also looked at the procedure for receiving assistance, including safeguards and protections, and issues related to eligibility and mental capacity. As in Committee, some of the proposed amendments would make significant changes. I want to comment on the correspondence from the relevant Ministers regarding the amendments. Their letter to Members quite properly explained that those amendments laid by the Bill's promoter, the hon. Member for Spen Valley (Kim Leadbeater), were considered workable by the Government, but the same could not be said about other amendments. It is important that the Minister emphasises, in his closing remarks, that that should not be read to mean that those amendments are not workable, which a superficial reading of the letter might imply; it just means that the Government have not given a view.

I have sympathy with the concerns raised by the hon. Members for Hackney South and Shoreditch (Dame Meg Hillier) and for Bradford West (Naz Shah) about the challenges for Members seeking to lay amendments without Government support. While all the normal conventions may have been followed, this is not a normal Bill, because of its significance and potential impact.

Several hon. Members *rose*—

Tom Tugendhat (Tonbridge) (Con): My hon. Friend will remember that in the last Parliament we brought in the National Security Act 2023, which introduced huge controls on the nature of an individual's liberty. The legislation passed through the House over a period of two years and required an entire Department to prepare it. There were considerations with the judiciary, foreign Governments and other services, including the police. The Bill before us allows the state to kill someone. Does he feel that this legislation is therefore somewhat more constrained than other legislation that would normally have been allowed to pass? And yes, it is correct to say that it allows the state—an actor on behalf of the state, at the request of an individual—to take a life. In the English language, that is called killing.

Dr Mullan: As I said, I recognise that the Bill is of greater significance than a typical private Member's Bill, but it has been delivered through the normal procedures of the House, and it is for the House as a whole to make those changes.

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

Sir John Hayes *rose*—

Dr Mullan: Not on that point.

We may wish to reflect on how we might change our approach to Bills like this one in the future, given the significant dissatisfaction that has been expressed with the manner in which it has been considered, even though it has been done in the ordinary way. But we are where we are.

As on Second Reading, this debate has been a balancing exercise. The promoter of the Bill and others have appropriately reminded us all of the very difficult and tragic experiences faced by the terminally ill and their families, but I respectfully say to the hon. Member for Spen Valley that we should be cautious in saying that opponents of the Bill are happy with the status quo, and I know that she would not have meant to suggest that.

Neil O'Brien: I am one of those people who is against the Bill, not in principle but for the reasons set out brilliantly by many articulate Labour Members. When my constituents ask what I think about this, I have no way of telling them; there is no way for me to get into the nuance of my position on it, because there has been no time to have a proper debate, and so many Members will now be unable to say a single thing about this totally transformative Bill.

Dr Mullan: My hon. Friend has added his concerns to those of others about the manner in which the debate has been conducted, but I reiterate that this has been done in the ordinary manner in terms of the Speaker's discretion and the Standing Orders of the House.

Opponents of the Bill are concerned that it will lead to a different set of unacceptable circumstances for different people; it is not that they are happy with how things are at the moment. All MPs have talked about people they care deeply about and how to help them. Whether they referred to disabled people, young people or the terminally ill, MPs have been speaking out in support of or against amendments, out of concern and compassion.

I may be tempting fate in saying that we might find consensus on advertising restrictions, but outside of that, Members have undoubtedly expressed a variety of strong views on others' amendments. It may be that Members vote consistently in line with whether they were originally for or against assisted dying, but other Members who are supportive of the Bill in principle are voting for restrictive amendments because they think that they are necessary. That is because this is a complex moral, legal and societal matter. I understand that Members are considering their votes with a degree of uncertainty.

There should be no shame at all in Members' admitting that they will be daunted by the sheer number of potential changes to the Bill, not to mention the decisions from the Speaker on those we are going to vote on or the challenge of deciding how to vote on each of them, either today or on a future day.

Sir John Hayes: Will my hon. Friend give way?

Dr Mullan: No, I need to make progress. They will be daunted not least because, although we have international examples, we are considering a novel practice in this country in our particular circumstances.

Members who are generally supportive or opposed in principle may choose to abstain on a number of amendments on which they feel that they are unable to give a definitive view and are content to vote on the final outcome on Third Reading. That would be understandable. I know that Members have considered how they will vote very carefully, and that they will continue to do so, by taking into account their views and experiences, as well as those of their constituents, other Members whom they respect, and experts and campaigning organisations. We will all be directly accountable to our constituents at the next election for all our votes throughout this Parliament.

[Dr Mullan]

That brings me to the remarks that I said I would like to finish with on the responsibilities of the public and campaigners towards MPs as they consider our votes. As we are first and foremost public servants, the focus is quite rightly usually almost entirely on the responsibility of MPs to the public, but as with all meaningful relationships, this is, and should always be, a two-way street. I accept the very strong feelings and deeply personal experiences that are brought to bear for those people contacting their MPs, and nothing I say should be taken as diminishing the rights of campaigners to make their cases strongly and consistently, but I and others have experienced lobbying by campaigners whose passion for securing the outcome they want has led them to question the integrity, sincerity or understanding of those MPs seeking a different outcome to them.

Some high-profile campaigners have made unhelpful remarks. Although I am not religious, I was concerned to see the clumsy criticism of those whose objections to the Bill are thought to be centred in their religious beliefs, as was mentioned by the hon. Members for Vauxhall and Camberwell Green (Florence Eshalomi) and for Lowestoft (Jess Asato).

Naz Shah: Will the hon. Gentleman give way?

Dr Mullan: I need to make progress.

I say that not least because I suspect that a very large number of supporters of the Bill might draw on their Christian or other religious compassion to explain why they want to see it pass. There was widespread reporting of how powerful the Second Reading debate was in showcasing the best of Parliament, with thoughtful debate and a consideration of nuanced and varied viewpoints. If Parliament demonstrates itself at its best, that creates a call for the public to do the same.

Gregory Stafford: I agree with the shadow Minister that the Second Reading debate was Parliament at its best. Would he say that the length of time that we have had to debate the Bill today, given the number of amendments and the number of people who wanted to speak, showed Parliament at its best?

Dr Mullan: I have expressed my views on that matter. I understand why Members are concerned, but it has been in order, and at your discretion, Mr Speaker.

MPs who disagree with campaigners' views for or against assisted dying are not uncaring or lacking in compassion. They have not failed to understand the arguments; they have just inevitably disagreed with at least some of their constituents. I urge campaigners to use their passion and commitment to the cause to fuel their campaigning, as is their right, but to pause and reach understanding before criticising an MP simply because they have reached a different view on a very challenging matter.

In a democracy, the public are as important as politicians in determining the quality of our discourse. I hope that my remarks remind people of that, and encourage them to aspire to be the best example of the behaviour that they want to see from their elected representatives, just as we have seen again in the Chamber today.

Anna Dixon: On a point of order, Mr Speaker. I appreciate that you and the team have had a very difficult day, but as someone who tabled an amendment but has not had the opportunity to speak to it, I would like clarification that if a closure motion is moved, my amendment, as well as those tabled by other Members who have been unable to speak to them, will not receive further debate.

Mr Speaker: To be quite honest with you, the amendments that we have discussed are the ones that we have got through. On the amount of time allocated, in fairness, we are presuming what will come next. I am going to call the Minister; if a closure motion is moved, I will decide at that moment whether to accept it. The fact that many amendments may not have been spoken to is not unusual, which is why consideration will not last for one day, as per the normal procedure; it will continue over further days, on which further amendments will be discussed, and of course there will be Third Reading at a later date. I call the Minister.

The Minister for Care (Stephen Kinnock): Thank you, Mr Speaker, and I thank Members across the House for their excellent contributions to the debate. As Members will know, the Government remain neutral on the passage of the Bill, promoted by my hon. Friend the Member for Spen Valley (Kim Leadbeater), and on the principle of assisted dying, which we have always been clear is a decision for Parliament. I therefore begin by clarifying that I am speaking in today's debate as the Minister responsible, jointly with my hon. and learned Friend the Member for Finchley and Golders Green (Sarah Sackman), for ensuring that the Bill, if passed, is effective, legally robust and workable. She and I were pleased to be members of the Bill Committee, again to provide advice on the workability and technical effectiveness of the Bill as it went through detailed line-by-line scrutiny.

I will not, therefore, give a Government view on the merits of any individual amendments in terms of their policy intent, as defined by the Member who tabled them, as that is rightly a matter for the House to decide. I will instead focus my remarks on amendments that the Government deem to give rise to significant workability concerns, and those amendments that have been tabled by my hon. Friend the Member for Spen Valley with technical drafting support from the Government, which have been developed to ensure that the Bill is technically and legally workable.

While I will not give an assessment of all the amendments tabled by other Members, I ask the House to note that they have not been drafted on the basis of advice or with technical drafting support from officials. Therefore, the Government are unable to confirm that those amendments are fully workable, effective or enforceable, though I acknowledge the point made by the hon. Member for Bexhill and Battle (Dr Mullan).

I will begin with obligations, duties and protections for medical practitioners. New clause 10 and amendment 52, tabled by my hon. Friend the Member for Spen Valley, replace clause 28 and expand the safeguards to ensure that no person is under any duty to participate. The new clause also clarifies several functions where certain professions or persons are under no duty to participate, including social care workers, pharmacists or persons acting as a proxy or witness. Finally, it provides that certain functions cannot be opted out of—for example, the recording of matters in a personal medical record.

New clause 11 and consequential amendments 64 and 65, also tabled by my hon. Friend, provide for the replacement of the co-ordinating or independent doctor where that doctor is unable or unwilling to continue to carry out their functions under the Bill, other than through illness or death. A number of amendments have been tabled in this area by other Members, and I shall briefly set out the Government's analysis of them.

1.45 pm

Amendment (a) to new clause 10 would allow an employer to prevent their employees from participating in the provision of assisted dying. It is not clear how that is intended to work alongside other obligations on professionals to perform certain duties laid out elsewhere in the Bill. As a result, employees may end up with conflicting obligations. It is also not clear how the amendment will work with the protection for employees from detriment and unfair dismissal by their employers should they choose to participate in the provision of assisted dying. If employers can prevent their entire workforce from participating in the provision of assisted dying, the service might not be available or could be much more difficult to access.

New clauses 17 and 18 would require a person to leave the care home in which they reside to access assistance under the Bill. When a person permanently resides in a care home, that is treated as their private home, so there is the potential for human rights issues to be raised later on: specifically, a person's right to respect for private and family life under article 8 of the European convention on human rights.

New clause 17 would prevent regulated care homes and hospices from facing any detrimental consequences for not providing or permitting assistance in accordance with the Bill. It would also provide that their funding must not be conditional on them providing or permitting such assistance to take place on their premises. New clause 18, in introducing a statutory right for a care home or hospice provider to decide whether they wish to provide or permit assistance to be provided on their premises, would similarly mean that a person who is terminally ill could be asked or required to leave that care home or hospice to receive assistance under the Bill.

Several hon. Members *rose—*

Stephen Kinnock: I will just make a little progress.

Amendment 60 may similarly prevent access to an assisted death for those residing within a care home or hospice, if that care home or hospice decided it would not allow such assistance on its premises.

Sir Edward Leigh: The Minister is making a very important point, and this is what I dealt with in my few short remarks. If, according to the Minister, care homes run by religious orders will have to provide this service, those orders will have to get out of care homes altogether.

Stephen Kinnock: I thank the right hon. Gentleman for that intervention. As I say, the Government do not take a position on the policy intent that my hon. Friend the Member for Spen Valley has set out. I would simply observe that if somebody has been in a home for a considerable period of time, that home is then considered to be their home. As such, any action to take them out of that home could engage article 8 of the ECHR, on the right to family life.

I now turn to the procedure for receiving assistance under the Bill, including safeguards and protections. First, I will speak to the amendments that have been tabled by my hon. Friend the Member for Spen Valley with technical workability and drafting advice from the Government.

Amendment 58 clarifies the duty on the Secretary of State to make through regulations provisions for training about reasonable adjustments and safeguards for autistic people and those with a learning disability. That remedies previously unclear wording in the Bill. Amendment 60 is required to make provision for circumstances where the independent doctor dies or, through illness, is unable or unwilling to act as the independent doctor. Amendments 67 and 68, tabled by my hon. Friend the Member for Spen Valley, clarify that an approved substance can be self-administered using a device should the individual be unable to self-administer without one. Amendment 91 gives effect to amendment 273, which was accepted in Committee, by ensuring that data will be recorded in the final statement to ensure coherence within the Bill.

I turn now to the amendments tabled by other Members on the subject of procedure, safeguards and protections that the Government have assessed may create workability issues if voted into the Bill. New clause 7 would limit the number of times two doctors can be jointly involved in the assessment of a person seeking assisted dying to three times within a 12-month period. In situations where there is a limited pool of doctors in any geographical location or area of medicine, that could limit access to assisted dying and create inequalities in access. New clause 9 would require the co-ordinating doctor, independent doctor and assisted dying review panels to apply the criminal standard of proof that requires them to be satisfied beyond reasonable doubt. Cases considered by the panel are civil matters, and as such it would not be usual practice for the criminal standard of proof to be applied to their decision making—and it is a very high bar. The provision would also impose additional standards on the assessing doctor that fall outside the usual framework for medical decision making.

Gregory Stafford: Is the Minister saying that, in his view, it is better that someone who should not die does die, than that someone who should die does not?

Stephen Kinnock: As a Minister at the Dispatch Box, with the Government being neutral, I am not commenting on the policy intent of the Bill. What I am saying is that the new clause could create significant uncertainty. For example, it is not clear how the standard it introduces would interact with the definition of "terminal illness" set out in clause 2, which requires that a person's death

"can reasonably be expected within six months",

as it is not clear whether "reasonably be expected" fits within the balance of probabilities threshold or is beyond reasonable doubt.

Amendment 101 would exclude any person with a learning disability, including people with Down syndrome, from a preliminary discussion about assisted dying unless

[Stephen Kinnock]

they raise the subject themselves, irrespective of whether they would otherwise be eligible. That may be subject to challenge under various international agreements, including the United Nations convention on the rights of persons with disabilities and article 14 of the European convention on human rights, which prohibits disability discrimination.

Amendment 102 would introduce a requirement that

> "the registered medical practitioner must ensure that the person has no remediable suicide risk factors which pose a significant risk to their life"

before holding a preliminary discussion under clause 5. The terms "remediable suicide risk factors" and

> "a significant risk to their life"

have not been defined, so the amendment may be difficult to operationalise.

Rebecca Smith (South West Devon) (Con): I tabled amendment 102 in good faith, as I thought it might be workable.

I want to reflect on what the Minister said at the beginning of his speech. I do not recall ever being offered an opportunity to pass my amendments to Government officials to ensure that they would be workable. Given the scope of what we are debating this afternoon, it sounds very much like any amendments that have not been tabled by the hon. Member for Spen Valley (Kim Leadbeater) had no chance of being taken forward unless she accepted them.

Hon. Members: Hear, hear.

Stephen Kinnock: I thank the hon. Lady for her intervention. She may have noted the comment from the hon. Member for Bexhill and Battle: approximately 500 amendments were tabled in Committee, and approximately one third of them were accepted. There was a pretty robust process for looking at whether amendments were acceptable, and the Government were involved in commenting and advising on all of them.

Dr Ben Spencer: Will the Minister give way?

Stephen Kinnock: I will make some progress, if I may.

Amendment 87 would require the co-ordinating doctor to "take all reasonable steps" to establish whether a first declaration had previously been made, so it may slow down the process for accessing assisting dying.

Amendment 45 would significantly impact the operability of the Bill. It would duplicate the role of the assisted dying review panel, and place an additional burden on the co-ordinating doctor to convene the clinical panel. It would also require additional NHS and social care resources, particularly palliative care consultants. That could slow down a person's access to an assisted death, because there is no requirement on when the panel must be convened, and it could take some time to set up, given the demands on health and social care professionals. The amendment does not specify who is to be on the clinical panel in situations where the co-ordinating doctor is neither a GP nor a consultant. Similarly, there is no provision for whether the clinical panel is to make its decisions unanimously or by majority.

Amendment 48 would require significant changes to the functions and focus of the bodies that are proposed to present arguments to the panel as to why a certificate of eligibility could not be granted. Where an official solicitor acts as an advocate to the court, their purpose is to assist the court on a difficult or novel point of law, not to perform an adversarial function. Similarly, there is no precedent for the Attorney General, His Majesty's Procurator General or the Treasury Solicitor to intervene in a case in the way that is envisaged, as their roles are to act on behalf of, or provide advice to, the Government, and not to represent a specific argument. In the Government's view, there are no existing public bodies that are well suited to undertaking this adversarial role.

Graham Stuart: Has the Minister any sympathy with the point made by my right hon. and learned Friend the Member for Kenilworth and Southam (Sir Jeremy Wright)? The panel might struggle to get the evidence it needs to make a decision, and there is no mechanism to address a situation in which, in the absence of that evidence, the panel makes a decision, but evidence then comes forward that suggests that its decision was incorrect. Does the Minister have any workable ideas for addressing that issue?

Stephen Kinnock: Clause 15 sets out the process that the panel must go through. It includes a right for the panel to request information and input from a range of potentially interested people. Clause 15(4)(d) appears already to cater for the intended effect of the amendment in the name of the right hon. and learned Member for Kenilworth and Southam (Sir Jeremy Wright).

Several hon. Members *rose—*

Stephen Kinnock: I will give way one final time.

Sir Jeremy Wright: I am conscious of the confines of the Minister's role in the process, but what assessment have the Government made of the capacity of a panel to investigate for itself anything that is not brought before it either by one of the relevant doctors or by the person seeking a certificate? The panel's capacity to do so is surely important, if any issue that is not raised by either group is relevant to its consideration.

Stephen Kinnock: The Government's position on the relevant clause is that the panel has to be satisfied that the correct steps have been taken, and there is not evidence of the points that the right hon. and learned Gentleman has made. Our view is that the intended effect is already catered for in clause 15.

Amendment 38 would exclude from being provided with assistance a person who is not already terminally ill, as defined under the Bill. The reference to "standard medical treatment" is unclear. This could cause further uncertainty around eligibility, given that treatment could be individually tailored to each patient and their needs.

Amendment 81 would remove the requirement that any references to capacity in the Bill are to be read in accordance with the Mental Capacity Act 2005. That would effectively remove the definition of capacity in the Bill. In the absence of a new definition, the Mental Capacity Act may continue to apply by default. That would, of course, diverge from the familiar concepts in the Mental Capacity Act, which could create confusion for practitioners.

The stated intention of amendment 14 is to exclude a person who would not otherwise meet the definition of "terminally ill" if the person meets that definition solely as a result of voluntarily stopping eating or drinking. Our assessment is that the amendment risks introducing uncertainty over a person's eligibility for assistance under the Bill. However, the substantive question is a policy choice for Parliament. Recognising the intent of the amendment, we do not believe that it would render the Bill unworkable.

Once again, I thank all hon. Members for their contributions. I hope that these observations have helped them in their consideration of the amendments that have been tabled.

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

Question put forthwith, That the Question be now put.

The House proceeded to a Division.

Mr Speaker: There is a delay in the No Lobby. Will the Serjeant at Arms please go and inspect?

The House having divided: Ayes 288, Noes 239.

Division No. 202] [1.58 pm

AYES

Abbott, Jack
Akehurst, Luke
Alexander, rh Mr Douglas
Alexander, rh Heidi
Al-Hassan, Sadik
Anderson, Callum
Antoniazzi, Tonia
Aquarone, Steff
Athwal, Jas
Atkinson, Lewis
Babarinde, Josh
Bailey, Mr Calvin
Ballinger, Alex
Barker, Paula
Barros-Curtis, Mr Alex
Beales, Danny
Beavers, Lorraine
Bedford, Mr Peter
Bell, Torsten
Benn, rh Hilary
Bennett, Alison
Berry, Siân
Betts, Mr Clive
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
Cadbury, Ruth
Campbell, rh Sir Alan
Campbell, Irene
Cane, Charlotte
Carling, Sam
Carmichael, rh Mr Alistair
Cartlidge, James
Chadwick, David
Chambers, Dr Danny
Champion, Sarah
Charters, Mr Luke
Chowns, Ellie
Clifton-Brown, Sir Geoffrey
Collier, Jacob
Collinge, Lizzi
Collins, Victoria
Coombes, Sarah
Cooper, Andrew
Cooper, Dr Beccy
Cooper, Daisy
Costigan, Deirdre
Cox, Pam
Creasy, Ms Stella
Curtis, Chris
Daby, Janet
Dance, Adam
Darlington, Emily
Davey, rh Ed
Davies, Ann
Davies, Paul
Davies-Jones, Alex
Davis, rh David
Dean, Bobby
Dean, Josh
Dearden, Kate
Denyer, Carla
Dickson, Jim
Dinenage, Dame Caroline
Dixon, Samantha
Dollimore, Helena
Dowden, rh Sir Oliver
Downie, Graeme
Duncan-Jordan, Neil
Dyke, Sarah
Eagle, Dame Angela
Eagle, rh Maria
Eccles, Cat
Edwards, Lauren
Edwards, Sarah
Egan, Damien
Elmore, Chris
Fahnbulleh, Miatta
Falconer, Mr Hamish
Farnsworth, Linsey
Fenton-Glynn, Josh
Ferguson, Mark
Fleet, Natalie
Fookes, Catherine
Foord, Richard
Forster, Mr Will
Foster, Mr Paul
Fox, Sir Ashley
Franklin, Zöe
Furniss, Gill
Garnier, Mark
Gelderd, Anna
Gemmell, Alan
George, Andrew
German, Gill
Gibson, Sarah *(Proxy vote cast by Anna Sabine)*
Gilbert, Tracy
Gilmour, Rachel
Gittins, Becky
Glover, Olly
Goldman, Marie
Gordon, Tom
Gosling, Jodie
Gould, Georgia
Green, Sarah
Greenwood, Lilian
Griffith, Dame Nia
Hack, Amanda
Hall, Sarah
Hatton, Lloyd
Hayes, Tom
Hazelgrove, Claire
Heylings, Pippa
Hinchliff, Chris
Hobhouse, Wera
Hopkins, Rachel
Hughes, Claire
Hume, Alison
Irons, Natasha
Jardine, Christine
Jarvis, Dan
Jarvis, Liz
Johnson, rh Dame Diana
Jones, Clive
Jones, Gerald
Jones, Louise
Jones, Sarah
Juss, Warinder
Kane, Chris
Kearns, Alicia *(Proxy vote cast by Kit Malthouse)*
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
Lightwood, Simon
MacCleary, James
Macdonald, Alice
MacNae, Andy
Maguire, Ben
Maguire, Helen
Malthouse, rh Kit
Martin, Amanda
Martin, Mike
Mather, Keir
Mayer, Alex
Maynard, Charlie
McCarthy, Kerry
McDonnell, rh John
McGovern, Alison
McIntyre, Alex
McKenna, Kevin
McMahon, Jim
McMorrin, Anna
McNeill, Kirsty
Medi, Llinos
van Mierlo, Freddie
Milne, John
Mishra, Navendu
Mitchell, rh Sir Andrew
Moon, Perran
Moran, Layla *(Proxy vote cast by Zöe Franklin)*
Morden, Jessica
Morello, Edward
Morgan, Helen
Morris, Joe
Munt, Tessa
Murphy, Luke
Murray, Chris
Murray, rh Ian *(Proxy vote cast by Chris Elmore)*
Murray, James
Murray, Susan
Myer, Luke
Naish, James
Naismith, Connor
Nash, Pamela
Niblett, Samantha
Norris, Alex
Norris, Dan *(Proxy vote cast by Chris Elmore)*
Onn, Melanie
Opher, Dr Simon
Osborne, Kate *(Proxy vote cast by Tom Rutland)*
Osborne, Tristan
Payne, Michael
Pearce, Jon
Pennycook, Matthew
Perkins, Mr Toby
Perteghella, Manuela
Phillips, Jess
Philp, rh Chris
Pitcher, Lee
Platt, Jo
Pollard, Luke
Powell, Joe
Powell, rh Lucy
Poynton, Gregor
Prinsley, Peter
Race, Steve
Ramsay, Adrian

Ranger, Andrew
Reed, rh Steve
Reeves, rh Ellie
Reynolds, Emma
Reynolds, Mr Joshua
Richards, Jake
Riddell-Carpenter, Jenny
Rigby, Lucy
Robertson, Dave
Roca, Tim
Roome, Ian
Russell, Sarah
Rutland, Tom
Ryan, Oliver
Sabine, Anna
Sackman, Sarah
Sandher, Dr Jeevun
Savage, Dr Roz
Saville Roberts, rh Liz
Sewards, Mark
Shanker, Baggy
Shastri-Hurst, Dr Neil
Siddiq, Tulip
Simons, Josh
Slade, Vikki
Slaughter, Andy
Slinger, John
Smart, Lisa
Smith, Cat
Smith, Jeff
Smyth, Karin
Sobel, Alex
Sollom, Ian
Stainbank, Euan
Stevens, rh Jo
Stewart, Elaine
Stone, Will
Strathern, Alistair
Swallow, Peter
Tapp, Mike
Taylor, David
Taylor, Luke
Taylor, Rachel
Thomas, Cameron
Thomas, Gareth
Thompson, Adam
Thornberry, rh Emily
Tice, Richard
Tidball, Dr Marie
Toale, Jessica
Tufnell, Henry *(Proxy vote cast by Adam Jogee)*
Uppal, Harpreet
Vaughan, Tony
Vince, Chris
Voaden, Caroline
Wakeford, Christian
Webb, Chris
Welsh, Michelle
West, Catherine
Western, Andrew
Western, Matt
Wheeler, Michael
Whitby, John
White, Jo
White, Katie
Whittome, Nadia
Wild, James
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)*
Abrahams, Debbie
Adam, Shockat
Ahmed, Dr Zubir
Alaba, Mr Bayo
Ali, Rushanara
Allin-Khan, Dr Rosena
Allister, Jim
Amos, Gideon
Anderson, Fleur
Anderson, Lee
Anderson, Stuart
Andrew, rh Stuart
Argar, rh Edward
Arthur, Dr Scott
Asato, Jess
Asser, James
Atkinson, Catherine
Bailey, Olivia
Baines, David
Baker, Alex
Baker, Richard
Baldwin, Dame Harriett
Bance, Antonia
Baxter, Johanna
Begum, Apsana *(Proxy vote cast by Zarah Sultana)*
Bhatti, Saqib
Billington, Ms Polly
Blackman, Bob
Bool, Sarah
Bowie, Andrew
Brackenridge, Mrs Sureena
Bradley, rh Dame Karen
Braverman, rh Suella
Burghart, Alex
Burgon, Richard
Burton-Sampson, David
Butler, Dawn
Byrne, rh Liam
Caliskan, Nesil
Campbell, Mr Gregory
Campbell, Juliet
Campbell-Savours, Markus
Clark, Feryal
Cleverly, rh Sir James
Cocking, Lewis
Coleman, Ben
Collins, Tom
Conlon, Liam
Cooper, John
Corbyn, rh Jeremy
Costa, Alberto
Coutinho, rh Claire *(Proxy vote cast by Danny Kruger)*
Cox, rh Sir Geoffrey
Craft, Jen
Creagh, Mary
Crichton, Torcuil
Cross, Harriet
Dalton, Ashley
Darling, Steve
Davies, Jonathan
Davies, Mims
Davies, Shaun
De Cordova, Marsha
Dewhirst, Charlie
Dhesi, Mr Tanmanjeet Singh
Dixon, Anna
Dodds, rh Anneliese
Doughty, Stephen
Duffield, Rosie
Duncan Smith, rh Sir Iain
Easton, Alex
Eastwood, Sorcha
Ellis, Maya
Eshalomi, Florence
Evans, Chris
Evans, Dr Luke
Farage, Nigel
Farron, Tim
Fortune, Peter
Foxcroft, Vicky
Foy, Mary Kelly
Francis, Daniel
French, Mr Louie
Frith, Mr James
Furniss, Gill
Gardiner, Barry
Gardner, Dr Allison
Glen, rh John
Glindon, Mary
Grady, John
Grant, Helen
Griffiths, Alison
Gwynne, Andrew *(Proxy vote cast by Chris Elmore)*
Harding, Monica
Hardy, Emma
Harris, Rebecca
Hayes, Helen
Hayes, rh Sir John
Hillier, Dame Meg
Hinder, Jonathan
Hinds, rh Damian
Hoare, Simon
Holmes, Paul
Huddleston, Nigel
Hudson, Dr Neil
Huq, Dr Rupa
Hurley, Patrick
Hussain, Mr Adnan
Hussain, Imran
Ingham, Leigh
Jameson, Sally
Jenrick, rh Robert
Jermy, Terry
Jogee, Adam
Johnson, Dr Caroline
Jones, rh Darren
Jones, Lillian
Jopp, Lincoln
Josan, Gurinder Singh
Joseph, Sojan
Kane, Mike
Kaur, Satvir *(Proxy vote cast by Darren Paffey)*
Khan, Ayoub
Kohler, Mr Paul
Kruger, Danny
Kumaran, Uma
Lam, Katie
Lamb, Peter
Lamont, John
Leigh, rh Sir Edward
Lewell, Emma
Lewis, rh Sir Julian
Lockhart, Carla
Lopez, Julia
Lowe, Rupert
MacDonald, Mr Angus
Madders, Justin
Mahmood, rh Shabana
Malhotra, Seema
Maskell, Rachael
Mathew, Brian
Mayhew, Jerome
McAllister, Douglas
McCluskey, Martin
McDonagh, Dame Siobhain
McDonald, Chris
McDougall, Blair
McEvoy, Lola
McKee, Gordon
McKinnell, Catherine
McMurdock, James
McNally, Frank
Midgley, Anneliese
Minns, Ms Julie
Mohamed, Iqbal
Mohindra, Mr Gagan
Moore, Robbie
Morris, Grahame
Morrissey, Joy
Mullane, Margaret
Mundell, rh David
Murray, Katrina
Newbury, Josh
Obese-Jecty, Ben
O'Brien, Neil
Olney, Sarah
Onwurah, Chi
Oppong-Asare, Ms Abena
Osamor, Kate
Owatemi, Taiwo
Paffey, Darren
Patel, rh Priti
Patrick, Matthew
Paul, Rebecca
Peacock, Stephanie
Phillipson, rh Bridget
Pinkerton, Dr Al
Pinto-Duschinsky, David
Pochin, Sarah
Pritchard, rh Mark
Quigley, Mr Richard
Rankin, Jack
Reader, Mike
Reed, David
Rhodes, Martin
Ribeiro-Addy, Bell
Rimmer, Ms Marie
Robinson, rh Gavin
Rodda, Matt
Rosindell, Andrew
Rushworth, Sam
Scrogham, Michelle
Shah, Naz
Shanks, Michael
Shannon, Jim

Simmonds, David
Smith, David
Smith, Greg
Smith, rh Sir Julian
Smith, Rebecca
Smith, Sarah
Snowden, Mr Andrew
Spencer, Dr Ben
Spencer, Patrick *(Proxy vote cast by Danny Kruger)*
Stafford, Gregory
Stephenson, Blake
Stevenson, Kenneth
Stone, Jamie
Streeting, rh Wes
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
Tugendhat, rh Tom
Turner, Laurence
Twist, Liz
Vaz, rh Valerie
Vickers, Martin
Vickers, Matt
Ward, Melanie
Whately, Helen
Whittingdale, rh Sir John
Williams, David
Williamson, rh Sir Gavin
Wilson, rh Sammy
Wood, Mike
Woodcock, Sean
Wright, rh Sir Jeremy

Tellers for the Noes:
Patricia Ferguson and Ruth Jones

Question accordingly agreed to.

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

Question agreed to.

New clause 10 accordingly read a Second time.

Amendment proposed to new clause 10: (a), after subsection (8)(b) insert—

> "(8A) Nothing in Schedule (Protection from Detriment) prevents an employer who has chosen not to participate in the provision of assistance in accordance with this Act from prohibiting their employees or workers from providing such assistance in the course of their employment or work with that employer."—*(Rebecca Paul.)*

This amendment ensures that employees who work for an employer who had chosen not to provide assisted dying cannot do so whilst working for that employer.

Question put, That the amendment be made.

The House proceeded to a Division.

Mr Speaker: Will the Serjeant at Arms inspect the Aye Lobby, as there appears to be a hold-up?

The House having divided: Ayes 243, Noes 279.

Division No. 203] **[2.15 pm**

AYES

Abbott, rh Ms Diane *(Proxy vote cast by Bell Ribeiro-Addy)*
Abrahams, Debbie
Adam, Shockat
Ahmed, Dr Zubir
Alaba, Mr Bayo
Ali, Rushanara
Allin-Khan, Dr Rosena
Allister, Jim
Amos, Gideon
Anderson, Fleur
Anderson, Lee
Anderson, Stuart
Andrew, rh Stuart
Argar, rh Edward
Arthur, Dr Scott
Asato, Jess
Asser, James
Atkinson, Catherine
Bailey, Olivia
Baines, David
Baker, Alex
Baker, Richard
Baldwin, Dame Harriett
Bance, Antonia
Baxter, Johanna
Begum, Apsana *(Proxy vote cast by Zarah Sultana)*
Bhatti, Saqib
Billington, Ms Polly
Blackman, Bob
Bool, Sarah
Bowie, Andrew
Brackenridge, Mrs Sureena
Bradley, rh Dame Karen
Braverman, rh Suella
Burghart, Alex
Burgon, Richard
Butler, Dawn
Byrne, rh Liam
Caliskan, Nesil
Campbell, Mr Gregory
Campbell, Juliet
Campbell-Savours, Markus
Clark, Feryal
Cleverly, rh Sir James
Clifton-Brown, Sir Geoffrey
Cocking, Lewis
Collins, Tom
Conlon, Liam
Cooper, John
Corbyn, rh Jeremy
Costa, Alberto
Coutinho, rh Claire *(Proxy vote cast by Danny Kruger)*
Cox, rh Sir Geoffrey
Craft, Jen
Creagh, Mary
Crichton, Torcuil
Cross, Harriet
Dalton, Ashley
Darling, Steve
Davey, rh Ed
Davies, Jonathan
Davies, Mims
De Cordova, Marsha
Dewhirst, Charlie
Dhesi, Mr Tanmanjeet Singh
Dixon, Anna
Dodds, rh Anneliese
Doughty, Stephen
Duffield, Rosie
Duncan Smith, rh Sir Iain
Easton, Alex
Ellis, Maya
Eshalomi, Florence
Evans, Chris
Farage, Nigel
Farron, Tim
Fenton-Glynn, Josh
Ferguson, Patricia
Fortune, Peter
Foxcroft, Vicky
Foy, Mary Kelly
Francis, Daniel
Francois, rh Mr Mark
French, Mr Louie
Frith, Mr James
Gardiner, Barry
Gardner, Dr Allison
Glen, rh John
Glindon, Mary
Grady, John
Grant, Helen
Griffith, Dame Nia
Griffiths, Alison
Gwynne, Andrew *(Proxy vote cast by Chris Elmore)*
Harding, Monica
Hardy, Emma
Harris, Rebecca
Hayes, Helen
Hayes, rh Sir John
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
Ingham, Leigh
Jameson, Sally
Jenrick, rh Robert
Jogee, Adam
Johnson, Dr Caroline
Jones, Lillian
Josan, Gurinder Singh
Joseph, Sojan
Kane, Mike
Kaur, Satvir *(Proxy vote cast by Darren Paffey)*
Khan, Afzal
Khan, Ayoub
Kohler, Mr Paul
Kruger, Danny
Kumaran, Uma
Lake, Ben
Lam, Katie
Lamb, Peter
Lamont, John
Leigh, rh Sir Edward
Lewell, Emma
Lewis, rh Sir Julian
Lockhart, Carla
Lopez, Julia
Lowe, Rupert
MacDonald, Mr Angus
Madders, Justin
Mahmood, rh Shabana
Mak, Alan
Malhotra, Seema
Maskell, Rachael
Mathew, Brian
Mayhew, Jerome
McAllister, Douglas
McCluskey, Martin
McDonagh, Dame Siobhain
McDonald, Chris
McDougall, Blair
McEvoy, Lola
McIntyre, Alex
McKee, Gordon
McKinnell, Catherine
McMahon, Jim
McMurdock, James
McNally, Frank
Medi, Llinos
Midgley, Anneliese
Minns, Ms Julie
Mohamed, Iqbal
Mohindra, Mr Gagan
Moore, Robbie
Morello, Edward
Mullan, Dr Kieran
Mullane, Margaret
Mundell, rh David
Murray, Katrina
Myer, Luke
Naish, James
Narayan, Kanishka
Newbury, Josh
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
Paul, Rebecca
Peacock, Stephanie
Phillipson, rh Bridget
Pinkerton, Dr Al
Pinto-Duschinsky, David
Pritchard, rh Mark
Quigley, Mr Richard
Raja, Shivani *(Proxy vote cast by Mr Gagan Mohindra)*
Rankin, Jack
Reader, Mike
Reed, David
Ribeiro-Addy, Bell
Rimmer, Ms Marie
Robertson, Dave
Robinson, rh Gavin
Rodda, Matt
Rosindell, Andrew
Rushworth, Sam
Scrogham, Michelle
Shah, Naz
Shanks, Michael
Shannon, Jim
Simmonds, David
Smith, David
Smith, Greg
Smith, rh Sir Julian
Smith, Rebecca
Smith, Sarah
Snowden, Mr Andrew
Spencer, Dr Ben
Spencer, Patrick *(Proxy vote cast by Danny Kruger)*
Stafford, Gregory
Stephenson, Blake
Stevenson, Kenneth
Stone, Jamie
Streeting, rh Wes
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
Toale, Jessica
Tugendhat, rh Tom
Turner, Laurence
Vaz, rh Valerie
Vickers, Martin
Vickers, Matt
Ward, Melanie
Webb, Chris
Whately, Helen
Whittingdale, rh Sir John
Williams, David
Williamson, rh Sir Gavin
Wilson, rh Sammy
Wood, Mike
Woodcock, Sean

Tellers for the Ayes:
Ruth Jones and
Joy Morrissey

NOES

Abbott, Jack
Akehurst, Luke
Alexander, rh Mr Douglas
Alexander, rh Heidi
Al-Hassan, Sadik
Anderson, Callum
Antoniazzi, Tonia
Aquarone, Steff
Athwal, Jas
Atkinson, Lewis
Babarinde, Josh
Bailey, Mr Calvin
Ballinger, Alex
Barker, Paula
Barros-Curtis, Mr Alex
Beales, Danny
Beavers, Lorraine
Bedford, Mr Peter
Bell, Torsten
Benn, rh Hilary
Bennett, Alison
Berry, Siân
Betts, Mr Clive
Blake, Olivia
Blake, Rachel
Bloore, Chris
Bonavia, Kevin
Botterill, Jade
Brandreth, Aphra
Brash, Mr Jonathan
Brewer, Alex
Brickell, Phil
Brown-Fuller, Jess
Burke, Maureen
Burton-Sampson, David
Cadbury, Ruth
Campbell, rh Sir Alan
Campbell, Irene
Cane, Charlotte
Carling, Sam
Carmichael, rh Mr Alistair
Cartlidge, James
Chadwick, David
Chambers, Dr Danny
Champion, Sarah
Charters, Mr Luke
Chowns, Ellie
Collier, Jacob
Collinge, Lizzi
Collins, Victoria
Coombes, Sarah
Cooper, Andrew
Cooper, Dr Beccy
Cooper, Daisy
Costigan, Deirdre
Cox, Pam
Creasy, Ms Stella
Curtis, Chris
Daby, Janet
Dance, Adam
Darlington, Emily
Davies, Paul
Davies, Shaun
Davies-Jones, Alex
Davis, rh David
Dean, Bobby
Dean, Josh
Dearden, Kate
Denyer, Carla
Dickson, Jim
Dinenage, Dame Caroline
Dixon, Samantha
Dollimore, Helena
Dowden, rh Sir Oliver
Downie, Graeme
Duncan-Jordan, Neil
Dyke, Sarah
Eagle, Dame Angela
Eagle, rh Maria
Eccles, Cat
Edwards, Lauren
Edwards, Sarah
Egan, Damien
Elmore, Chris
Evans, Dr Luke
Fahnbulleh, Miatta
Falconer, Mr Hamish
Farnsworth, Linsey
Ferguson, Mark
Fleet, Natalie
Foody, Emma
Fookes, Catherine
Foord, Richard
Forster, Mr Will
Fox, Sir Ashley
Franklin, Zöe
Furniss, Gill
Garnier, Mark
Gelderd, Anna
Gemmell, Alan
George, Andrew
German, Gill
Gibson, Sarah *(Proxy vote cast by Anna Sabine)*
Gilbert, Tracy
Gilmour, Rachel
Gittins, Becky
Glover, Olly
Goldman, Marie
Gordon, Tom
Gosling, Jodie
Gould, Georgia
Green, Sarah
Greenwood, Lilian
Hack, Amanda
Hall, Sarah
Hatton, Lloyd
Hayes, Tom
Hazelgrove, Claire
Heylings, Pippa
Hinchliff, Chris
Hobhouse, Wera
Hopkins, Rachel
Hughes, Claire
Hume, Alison
Irons, Natasha
Jardine, Christine
Jarvis, Dan
Jarvis, Liz
Jermy, Terry
Johnson, rh Dame Diana
Jones, Clive
Jones, Gerald
Jones, Louise
Juss, Warinder
Kane, Chris
Kearns, Alicia *(Proxy vote cast by Kit Malthouse)*
Kendall, rh Liz
Kinnock, Stephen
Kirkham, Jayne
Kitchen, Gen
Kumar, Sonia
Kyle, rh Peter
Kyrke-Smith, Laura
Law, Noah
Leadbeater, Kim
Lewin, Andrew
Lightwood, Simon
MacCleary, James
Macdonald, Alice
MacNae, Andy
Maguire, Ben
Maguire, Helen
Malthouse, rh Kit
Martin, Amanda
Martin, Mike
Mather, Keir
Mayer, Alex
Maynard, Charlie
McCarthy, Kerry
McDonnell, rh John
McGovern, Alison
McKenna, Kevin
McMorrin, Anna
McNeill, Kirsty
van Mierlo, Freddie
Milne, John
Mishra, Navendu
Mitchell, rh Sir Andrew
Moon, Perran
Moran, Layla *(Proxy vote cast by Zöe Franklin)*
Morden, Jessica
Morello, Edward
Morgan, Helen
Morris, Joe
Munt, Tessa
Murphy, Luke
Murray, Chris
Murray, James
Murray, Susan
Naish, James
Naismith, Connor
Nash, Pamela
Niblett, Samantha
Norris, Alex
Norris, Dan *(Proxy vote cast by Chris Elmore)*
Onn, Melanie
Opher, Dr Simon
Osborne, Kate *(Proxy vote cast by Tom Rutland)*
Osborne, Tristan
Patrick, Matthew
Payne, Michael
Pearce, Jon
Pennycook, Matthew
Perkins, Mr Toby
Perteghella, Manuela
Phillips, Jess
Philp, rh Chris
Pitcher, Lee
Platt, Jo
Pochin, Sarah
Pollard, Luke
Powell, Joe
Powell, rh Lucy

Poynton, Gregor
Prinsley, Peter
Race, Steve
Ramsay, Adrian
Ranger, Andrew
Reed, rh Steve
Reeves, rh Ellie
Reynolds, Emma
Reynolds, Mr Joshua
Richards, Jake
Riddell-Carpenter, Jenny
Rigby, Lucy
Roca, Tim
Roome, Ian
Russell, Sarah
Rutland, Tom
Ryan, Oliver
Sabine, Anna
Sackman, Sarah
Sandher, Dr Jeevun
Savage, Dr Roz
Saville Roberts, rh Liz
Sewards, Mark
Shanker, Baggy
Shastri-Hurst, Dr Neil
Siddiq, Tulip
Simons, Josh
Slade, Vikki
Slaughter, Andy
Slinger, John
Smart, Lisa
Smith, Cat
Smith, Jeff
Smyth, Karin
Sobel, Alex
Sollom, Ian
Stainbank, Euan
Stevens, rh Jo
Stewart, Elaine
Stone, Will
Strathern, Alistair
Swallow, Peter
Tapp, Mike
Taylor, David
Taylor, Luke
Taylor, Rachel
Thomas, Cameron
Thomas, Gareth
Thompson, Adam
Thornberry, rh Emily
Tice, Richard
Tidball, Dr Marie
Tufnell, Henry *(Proxy vote cast by Adam Jogee)*
Uppal, Harpreet
Vaughan, Tony
Vince, Chris
Voaden, Caroline
Wakeford, Christian
Welsh, Michelle
West, Catherine
Western, Andrew
Western, Matt
Wheeler, Michael
Whitby, John
White, Jo
White, Katie
Whittome, Nadia
Wild, James
Witherden, Steve
Woodcock, Sean
Wrighting, Rosie
Wrigley, Martin
Yang, Yuan
Yemm, Steve
Young, Claire
Zeichner, Daniel

Tellers for the Noes:
Bambos Charalambous and Sarah Owen

Question accordingly negatived.

Motion made,

That new clause 10 be added to the Bill.—*(Kim Leadbeater.)*

Hon. Members: Object.

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

Bill to be further considered on Friday 13 June.

Business without Debate

ANIMAL WELFARE (RESPONSIBILITY FOR DOG ON DOG ATTACKS) 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.

SECURE 16 TO 19 ACADEMIES BILL

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

COURTS (REMOTE HEARINGS) BILL

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

BAILIFFS (WARRANTS OF POSSESSION) BILL

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

Hon. Members: Object.

Bill to be read a Second time on Friday 13 June.

NATIONAL HEALTH SERVICE CO-FUNDING AND CO-PAYMENT BILL

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

Hon. Members: Object.

Bill to be read a Second time on Friday 13 June.

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 20 June.

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 4 July.

POLITICAL DONATIONS 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.

ARMS TRADE (INQUIRY AND SUSPENSION) 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.

RIVERS, STREAMS AND LAKES (PROTECTED STATUS) BILL

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

Hon. Members: Object.

Bill to be read a Second time on Friday 4 July.

INTERPERSONAL ABUSE AND VIOLENCE AGAINST MEN AND BOYS (STRATEGY) BILL

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

Hon. Members: Object.

Bill to be read a Second time on Friday 13 June.

HERITAGE PUBLIC HOUSES BILL

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

Hon. Members: Object.

Bill to be read a Second time on Friday 20 June.

CHALK STREAMS (PROTECTION) BILL

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

Hon. Members: Object.

Bill to be read a Second time on Friday 20 June.

PETS (MICROCHIPS) BILL

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

Hon. Members: Object.

Bill to be read a Second time on Friday 13 June.

TERMINAL ILLNESS (RELIEF OF PAIN) BILL

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

Hon. Members: Object.

Bill to be read a Second time on Friday 13 June.

IMMIGRATION AND VISAS BILL

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

Hon. Members: Object.

Bill to be read a Second time on Friday 13 June.

Stockport Railway Station

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

2.36 pm

Navendu Mishra (Stockport) (Lab) [R]: I welcome the opportunity to debate the condition of Stockport railway station. I thank you, Madam Deputy Speaker, and Mr Speaker for granting time for the debate. I refer the House to my entry in the Register of Members' Financial Interests—in particular to the donations from trade unions to the Stockport constituency Labour party.

First, I thank all staff at Stockport station, including cleaners, security staff, engineers, ticket office staff, platform safety staff and everyone in the retail outlets. I am a frequent user of Stockport station, and I know that many of my parliamentary colleagues from Greater Manchester prefer to come to that station to get their train into London and will be familiar with its condition.

Stockport has a rich and proud railway heritage, and I welcome this debate as we mark 200 years of British railways. The magnificent Stockport viaduct, one of Stockport's most iconic landmarks, stands as a towering reminder of our town's long connection to the railway, dating back to the 19th century. Completed in 1840, it remains one of the largest brick building structures in the country, and is a marvel of Victorian engineering. The railway helped Stockport to become a key part of the north-west's industrial growth. It supported the growth of the cotton and hatting industries, connected workers to jobs and gave businesses access to markets across the country. I am not sure whether you have been to the Hat Works museum in Stockport, Madam Deputy Speaker, but may I invite you to visit?

Even today, the railway continues to shape our local economy, connecting us to Manchester, London and beyond. Greater Manchester is the fastest-growing economy in the UK. Its £80 billion economy has grown by 50% since 2000, with a 4.5% gross value added in 2022 alone. We need a first-class, high-quality and reliable railway station to continue facilitating that growth. Hundreds of trains, be they passenger or freight trains, pass through Stockport station. I welcome the Government's recent progress in establishing Great British Railways. The move to take passenger rail services into common ownership will allow for more reliable train services in Stockport and across the country. That was a key Labour manifesto promise, and we will deliver it in government.

Stockport is a busy and important station. The latest figures show 3.8 million entries and exits in the past year—just under 4 million. The most popular destination from Stockport station is Manchester Piccadilly, with around 1.3 million journeys on that route annually. We hear a lot about climate change, net zero and pledges to tackle global warming. It is really important to invest in our public transport infrastructure to give people the option of a reasonably priced, reliable, safe public transport network. If we want people to leave their cars and personal vehicles at home and use public transport, high-quality services must be available at the station.

One of the most serious issues that affects Stockport station is accessibility. Disabled passengers too often face faulty lifts and have no way to access the platforms.

Lisa Smart (Hazel Grove) (LD): I am grateful to my constituency neighbour for giving way in this really important debate. I started my journey to the Chamber today at Stockport station. I completely agree with his comments, but I wonder whether he would go further. Our ambition for accessibility on our railway network needs to expand beyond the mainline stations. Stockport is an extremely important station for my Hazel Grove constituents, but we need to ensure accessibility at stations such as Woodley, Rose Hill Marple and Romiley so that all passengers can access our railway network, not just those who have two legs that can get them up a steep slope.

Navendu Mishra: I agree entirely. To go back to my previous point, if we want people to use public transport, we need to offer services that match their needs. I lived in Hazel Grove for several years, and I know the stations that the hon. Lady mentions. I agree that Stockport is a large station—it had almost 4 million entries and exits in the last reporting period—but we should not overlook the smaller stations. Unfortunately, over the last few decades, the north and north-west of England has been overlooked when it comes to transport investment. I agree with the hon. Lady, and there is a lot to be said about people commuting from smaller stations to larger stations and getting connections to Manchester airport, Birmingham, Cornwall, London or even Scotland.

Disabled passengers too often face faulty lifts and have no way to access the platforms, and that problem is persistent across my constituency. Sadly, three out of five rail stations in my constituency—Brinnington, Heaton Chapel and Reddish South—do not have step-free access, and I want to see that addressed as soon as possible. It is simply unacceptable that disabled passengers, parents with pushchairs, older people and people who are less mobile than us are excluded from using their local stations with dignity and ease.

I want to put on the record my thanks to Nathaniel Yates, a local champion from the Reddish part of Stockport —I think the hon. Member for Hazel Grove (Lisa Smart) has met him—who has done a lot of work on step-free access at railway stations, not just in Stockport but across Greater Manchester.

Dame Meg Hillier (Hackney South and Shoreditch) (Lab/Co-op): I am sorry to intrude in a debate on Stockport railway station, but I feel a burning need to highlight the issues of Dalston Kingsland station. That railway line was the London Overground but the Mayor of London has renamed it different things in different areas, and that part is now the Mildmay line. That station has no lift, unlike others on that line. That really is a big issue, especially as it is close to the world-famous Ridley Road market, so it attracts a lot of visitors. I hope the Minister will cover how fast we can get lifts into stations without step-free access.

Navendu Mishra: I am not familiar with that station, but I agree wholeheartedly that people should not be excluded from our public transport network due to their physical ability. That is just not acceptable in modern Britain.

I want to call out the previous Conservative Government's plans to close hundreds of ticket offices, including at key stations such as Stockport. Those proposals were entirely unacceptable because they ignored the needs of disabled passengers, older travellers and anyone who is less able to use the internet. Disabled people already face numerous barriers in accessing the railway and are three times less likely to travel by rail than non-disabled people. That is why it is so important that we have good-quality, reliable infrastructure that supports disabled people, and lifts and doors that do not break down frequently, as they do at Stockport station. Ticket offices provide a fixed location for passengers to locate staff and, therefore, advice and assistance. That is particularly important for many disabled people, who are less able to search the station for a roaming member of staff.

The RMT union has long-standing concerns about Avanti's failure to fill station staff vacancies and its widespread reliance on fixed-term contracts. That understaffing is leading to delays at ticket offices and cases of ticket offices not being open during their advertised and regulated hours. That clearly impacts the passenger experience, safety and accessibility. Sadly, it seems that Avanti is putting private profits before public safety and accessibility. I am told that Avanti paid out shareholder dividends of £8.1 million in 2024. Ticket office staffing in Stockport is inconsistent and simply not good enough. The Government should instruct Avanti to permanently fill all existing vacancies, transfer staff on fixed-term contracts to permanent contracts and ensure its ticket offices and stations are properly staffed.

As I have noted, Stockport station is one of the busiest in Greater Manchester, yet its condition is far below what passengers deserve. I welcome the recent announcement by Network Rail to repair the frequently faulty lifts—£46,000 is being invested at the station to make step-free access more reliable for passengers—but that should be the start, not the end of the investment at our station. Basic maintenance is falling behind at the station, with leaking roofs, worn out toilets, and poor drainage causing repeated flooding on platforms.

One resident described the station as "incredibly uninviting". They said that the

> "lights are dim because they are covered in years of cobwebs and grime"

and that parts of the station are in "dire condition, often leaking". The station's pedestrian tunnel is dark, damp and neglected. One resident described it as being like an "old air raid shelter". Another resident said that the station feels "poor, tired and dark" and that she

> "doesn't feel safe travelling as a woman alone in the evening or early mornings".

Ticket vending machines are unreliable and the Edgely entrance to Stockport station is in a dire state. The station is well run but understaffed. Residents have reported to me a lack of gate staff, no permanent British Transport police presence, and serious concerns about road safety on the Edgeley entrance side. Tragically, there was recently a collision that left a member of the public injured on that side of the station, which was sad news.

I have raised these issues with Avanti. The broken main entrance door was finally replaced, but it should not have taken public shaming to get essential fixes done. While I welcome Network Rail's investment in the Greek Street bridge near the station—it is investing almost £20 million in that project—it needs to go further and faster in improving the station for all.

[Navendu Mishra]

I highlight that the viaduct, which I mentioned earlier, is an iconic part of Stockport's skyline, but it is not part of Stockport station. The investment of £20 million in the Greek Street bridge is also welcome, but that is not part of the station. We need ringfenced investment in the station. I was recently out with the Network Rail team—I think it was in February—who have spent almost £1.1 million cleaning up and repairing the viaduct. That is great news for our town and for railway users, but the station needs a lot of love and investment.

Many people rely on the station, whether for commuting across the north-west or visiting Birmingham or London, but it has been unfairly left behind. Stockport residents are calling for proper investment to bring the station in line with others across the region. They want safety, accessibility and basic decency.

On a different point, I take the opportunity to urge the Minister to back the extension of the Metrolink tram system to Stockport town centre. That investment would be a huge boost for Stockport's connectivity and local economy, helping people to get to work, school and healthcare appointments more easily and sustainably.

We have great connections from Stockport station, but sadly during covid TransPennine Express stopped direct services between Stockport and Manchester airport. I wrote to it but unfortunately got a disappointing response; I will be going back to it. I urge the Minister to visit it with me at some point.

The absence of a direct service from Stockport to Manchester airport creates unnecessary inconvenience for many residents, particularly those who rely on public transport for work. Manchester Airports Group is a large employer in my constituency, and many people commute from my constituency to Manchester airport. The indirect route is difficult for those carrying heavy luggage and for those who are less mobile or need assistance. I want to see that service reinstated as soon as possible.

I have mentioned this on a number of occasions in the Chamber, but may I pay tribute to the friends of Reddish South station? They are a brilliant community group in the Reddish part of Stockport who have worked tirelessly to improve their local railway station. They have been campaigning for years for proper rail services at Reddish South. Currently, Reddish South station has one train a week. Imagine having a local train station with one train a week—it is just ridiculous.

I echo the calls for further investment by Network Rail in better signalling in and around Stockport. Some of the engineering parts and equipment used around Stockport are quite dated. We need to ensure that the signalling infrastructure and equipment is the latest, cutting-edge equipment for safety standards and ease of use. We also need to unlock the future capability and reliability of our railway network, so that would be welcome. I am also very grateful to Friends of Heaton Chapel Station, who make a valuable and wonderful contribution to the community of Stockport.

I have gathered some feedback from members of staff at Stockport station, so I will quickly mention that. Many Members might be surprised to discover that we have an unusually named platform 0 at Stockport station. Sadly, due to staffing shortages platform 0 is often closed, because there are not enough Avanti staff. The Passenger Assist scheme, which is supposed to help those who are less mobile, those with health conditions or those with disabilities to access the railway, is a vital lifeline for many people. Unfortunately, I am told that the staffing for the Passenger Assist scheme is so poor at Stockport station that it is covered by one member of staff on a part-time basis. When that staff member is not in, platform staff, who should be focused on railway safety with trains arriving and departing, have to assist passengers. I recently tabled written parliamentary question 41630 on Passenger Assist. I thank the Minister and the Government for the £10 million to improve the Passenger Assist service. The capability to book a ticket, request assistance and reserve a seat in one single transaction will be widely welcomed by pretty much everyone—I cannot think of anyone who would be opposed to it.

British Transport police do a fantastic job, but they do not have a permanent presence at Stockport station and neither do we have permanent security staff. I call on Avanti and Network Rail to work together to resolve that.

I want Stockport station to be a place that residents can be proud of. The station is not just a local hub; it is a vital part of our critical national infrastructure. It deserves the investment, accessibility and support to match. Network Rail must accelerate investment in lifts, drainage, roofing and accessibility. More must be done to address basic maintenance failures before they become hazardous. I also want Avanti and Network Rail to work at pace to improve the staff facilities, which need to be upgraded. They do a fantastic job—I have already place on record my thanks to them—and they deserve good quality facilities when they take their breaks, and when they start and end their shifts.

I welcome the share of the city region sustainable transport settlements that Stockport will receive to progress development at Stockport station, but I urge the Minister to go further and faster with funding for modernisation and better connectivity at Stockport. I also ask the Minister to urge Avanti to end its over-reliance on temporary contracts and to fill ticket office vacancies. Sadly, I personally find that the ticket office at Stockport is frequently closed during advertised hours when it should be open. Ticket office closures risk denting revenue by deterring passengers, particularly disabled people, from using the railway. Passenger safety, service and accessibility are vital for a thriving railway.

I invite the Minister to visit Stockport again. I understand that he has been twice since he took up his position. Both times, he visited on a sitting day when I was in Westminster, so I invite him to visit again. I would love to take him to Reddish South station, which has one train a week; Stockport station, which has almost 4 million passenger rail entries and exits; and Brinnington and Heaton Chapel stations, which do not have step-free access.

I am grateful to many organisations, including the trade unions, which provided briefings for this debate. Avanti and Network Rail also helped me with a briefing. Nick from Avanti, in particular, has been really helpful. I conducted a survey on my Facebook page seeking feedback from residents and passengers on Stockport station. I received several submissions and I am so grateful to each and every one of the respondents for helping me to write this speech. I hope the Minister is able to address some of the points I have made, but my last point is that Network Rail and Avanti need to do so much more to make sure that Stockport station, and the smaller stations in Stockport, get the investment they have deserved for far too long.

2.53 pm

The Parliamentary Under-Secretary of State for Transport (Simon Lightwood): I congratulate my hon. Friend the Member for Stockport (Navendu Mishra) on securing the debate and providing the opportunity to discuss Stockport railway station. I thank the hon. Member for Hazel Grove (Lisa Smart) and my hon. Friend the Member for Hackney South and Shoreditch (Dame Meg Hillier) for their interventions.

Let me start by talking a little bit about this important train station. Stockport station is a vital transport interchange in south Greater Manchester. Sitting on the west coast main line approach to Manchester Piccadilly, it provides access and connectivity across the country to commuters, leisure travel and freight. On average, 501 passenger and freight trains pass through the station per day. That is 10,000 paying passengers a day, with 5,000 to 6,000 passing through the station.

The industry is working collaboratively to engage with local stakeholders who have concerns and a vision for the station. Network Rail's engagement with local stakeholders is fundamental to shaping plans for the future of the station, and it will continue to welcome input and to be transparent about timescales and issues as they arise.

The Stockport corridor is critical for a range of express, regional and local passenger services and freight. It supports some very important flows nationally as well as offering a key destination in the interchange hub at Stockport station itself. The route from Stockport into Manchester is very constrained, which means that it is extremely difficult to plan any additional services through it reliably. While other interfacing schemes might increase capacity and capability elsewhere on the network, the constraints at Stockport act as a bottleneck when trying to uplift service frequencies overall. Network Rail and the industry are working through the options to address capability and capacity, working with mayors and transport authorities on what future plans there could be for the Stockport corridor.

Lisa Smart: The Minister is talking about the assessment of various options. We know that the Treasury is looking at reviewing the contents of the Green Book that measures the benefits and disbenefits of any capital spending. Can he say a few words on how we can ensure that the north, particularly the Stockport area, gets its fair share of capital spending in the future to ensure that existing inequality is not baked into the calculations that the Treasury makes?

Simon Lightwood: We obviously want to see growth in every corner of the country, and we are awaiting the spending review outcomes, as is everybody else.

We are aware that our partners will have their own priorities for the future of railways in their areas, and we are open to engaging with them directly on their plans. The core aim of the Stockport station redevelopment scheme is to support future increases in rail patronage and green travel and to drive clean and sustainable economic growth. It will improve the accessibility, attractiveness and useability of Stockport station and reduce town centre severance.

There is an opportunity to leverage a package of works through the Greater Manchester authority's sustainable transport settlement funding for delivery by March 2027, which would include a refurbishment of platform buildings, with a focus on platforms 1 and 2. Stockport council, Network Rail and Avanti are meeting today to further scope out that work. Avanti West Coast has funds available for the current financial year to undertake works at the station, which will focus on staff facilities that need upgrading and some accessibility enhancements. We will share further information as those plans are developed.

I thank the hon. Member for Hazel Grove for her intervention, and I will touch on Passenger Assist. Avanti has seen a significant increase in passenger assistance over the last 12 months, and it is now reviewing its Passenger Assist process so that it can meet the needs of passengers on that service.

Navendu Mishra: I thank the Minister for making that point. I had a conversation with Avanti recently about the Passenger Assist scheme. The west coast main line network that Avanti services is a major network in this country, and Avanti should welcome the fact that more disabled people want to use its services. I am told by members of staff at the station, which has 3.8 million entries and exits per year, that one member of staff on a part-time basis supports Passenger Assist. I am sure the Minister will agree that that is simply not good enough and that Avanti needs to do a lot better.

Simon Lightwood: I want to see a railway and a transport system across the country that are accessible to everybody. I will take away my hon. Friend's comments on this individual case and discuss it further with the Rail Minister.

I also thank my hon. Friend the Member for Hackney South and Shoreditch. I am happy to meet with her to discuss the accessibility challenges that she has raised. I also look forward to meeting with Nathaniel Yates, who my hon. Friend quite rightly highlighted for his work on accessibility.

I will talk a little about some of the other major works carried out by Network Rail in and around Stockport. Network Rail is delivering a £20 million project to rebuild the Greek Street bridge, which carries a major road junction over the Manchester spur of the west coast main line in Stockport. Throughout the work, Network Rail has kept the local community informed with regular drop-in events, which have been well attended, and has received no complaints about the work since the closure of the road. The project team has an excellent presence on site, regularly checking in with neighbours, local businesses, schools and colleges in the area to reduce the impact of the works as much as possible.

Navendu Mishra: The Minister is being extremely generous. As I mentioned in my speech, I welcome the £20 million investment in the Greek Street bridge and the £1.1 million investment to clean the viaduct and repair the brickwork. But if we are being honest, the

[Navendu Mishra]

Greek Street bridge and the viaduct are not part of Stockport station. They are of course an essential part of our railway network, but I want to see real investment in Stockport station for passengers and staff members, so I hope Network Rail is watching and takes note of that.

Simon Lightwood: My hon. Friend is quite right, and I hear what he says, but it is important that we point out the wider investment in the rail system there, including the £1.1 million to refurnish the iconic Stockport viaduct, which was built back in 1840.

Let me move on to the issue of step-free access at Brinnington, Heaton Chapel and Reddish South stations, which I know my hon. Friend is interested in. Since its launch in 2006, the Access for All programme has delivered step-free access at more than 260 stations across Great Britain. Only about half of the stations in Great Britain have step-free access to and between all platforms. However, around 75% of journeys on the GB rail network are through step-free stations, compared with 50% in 2005. I recommend that my hon. Friend and his constituency neighbour, the hon. Member for Hazel Grove, engage with the local authority and Northern Trains to propose that Brinnington, Heaton Chapel and Reddish South are a priority in any future funding rounds, as none of those stations were nominated for the last round. In the meantime, the Department will continue to seek further opportunities to improve rail accessibility, and if the industry installs, replaces or renews infrastructure at the stations, that will need to comply with current accessibility standards.

On the services provided at Reddish South station, the Department expects operators to match the capacity and frequency of their services to demand, although they must also be operationally sustainable and deliver value for taxpayers. The Rail North partnership, through which the Department and Transport for the North jointly manage the contract with Northern Trains, which serves Reddish South, will assess any business case that is put forward. The analysis must balance the economic and social benefits of any enhancement with the performance of existing services and the financial impact of a taxpayer subsidy.

I turn to the direct service from Stockport to Manchester airport—an issue I know my hon. Friend the Member for Stockport is keen on. The Sheffield-Manchester airport service, which offered direct services between Stockport and the airport, was withdrawn in December 2022 as part of the timetable developed by the Manchester taskforce, which includes the DFT, the train operators, Network Rail, Transport for Greater Manchester and Transport for the North. We see improved connectivity as an important factor in growing the northern and national economies and would hope that new infrastructure would allow direct services from Stockport to the airport, although I must stress that other towns and cities could make a case for their pre-2022 direct connections to be restored as well.

I thank my hon. Friend again for the debate, at which we have discussed a number of important issues affecting rail services in his constituency. He rightly pointed out that I have visited his constituency not once but twice. I hope he does not take it personally that on each occasion it was a sitting day. I will do my utmost to return to Stockport—as long as he can guarantee that the sun is shining.

Question put and agreed to.

3.3 pm

House adjourned.

Written Statement

Friday 16 May 2025

DEFENCE

Afghan Special Forces Relocation Review

The Minister for the Armed Forces (Luke Pollard): Following my statement in the autumn of last year, I would like to further update the House on the progress of the Triples review.

In my previous statement on the Triples review, on 14 October 2024—Vol. 754, c. 612 of the *Official Report* —I committed to updating the House on the review's progress. I can now announce that the case work within the initial scope of the review has been completed, with approximately 30% of those decisions now overturned. We have continued to relocate and settle eligible Triples who supported the UK mission in Afghanistan to restart their life in UK. All eligibility decisions are made against policy considering the individual circumstances of the applicant, in line with UK immigration rules.

However, the work of the review is not yet complete. As I set out in my previous statement, officials have continued to analyse and strengthen their understanding of the payment records that the Ministry of Defence holds relating to members of Afghan partner forces.

Following further advice, I am now satisfied that, in addition to the payment records that for some Triples have been sufficient to evidence a direct employment relationship with HM Government, for others, top-up pay will also be sufficient in this context to demonstrate that they have worked alongside us. Further, it will mean that, in some cases, evidence of certain top-up payments will also be sufficient to demonstrate a substantive and positive contribution to the UK's military or national security objectives in Afghanistan due to the nature of the work undertaken by those individuals. This revised approach will make it more likely that some Triples previously found ineligible will secure a positive decision, if they can also demonstrate that they meet the other conditions for eligibility.

So I am today announcing that the Triples review will move into a second and final phase to ensure that all those impacted by this change in approach will have their case reviewed. This will include some applicants who were in scope of the original review, but also others who were not.

Further details on phase 2 of the review are available in the terms of reference, which will be published online in the coming days alongside the Afghan relocations and assistance policy criteria. We are also publishing more details of the earlier work, which will be known as phase 1 of the review.

I want to reiterate that I am committed to getting this right and I believe that launching a second and final phase of this review is the right thing to do, to ensure that we deliver on our moral obligation to all those who should be eligible. I can assure the House that all those who have already had their application reviewed under phase 1 and have had a fresh decision made have either been contacted or will be contacted in due course, and that all those who have decisions made throughout phase 2 will be contacted on a rolling basis.

All decisions made in phases 1 and 2 of the Triples review will also carry a right to have this decision reviewed. I am not going to fall into the trap, as the previous Government did, of committing to a timeline that is clearly not deliverable, but I will keep the House updated on progress, and I am personally invested and remain committed to completing this as quickly as possible.

Finally, as the Defence Secretary set out in his statement in December, the Government intend to reach a position where the UK Afghan resettlement schemes can be closed. We will update the House on this accordingly.

[HCWS645]

WRITTEN STATEMENT

Friday 16 May 2025

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Volume 767
No. 139

Friday
16 May 2025

CONTENTS

Friday 16 May 2025
