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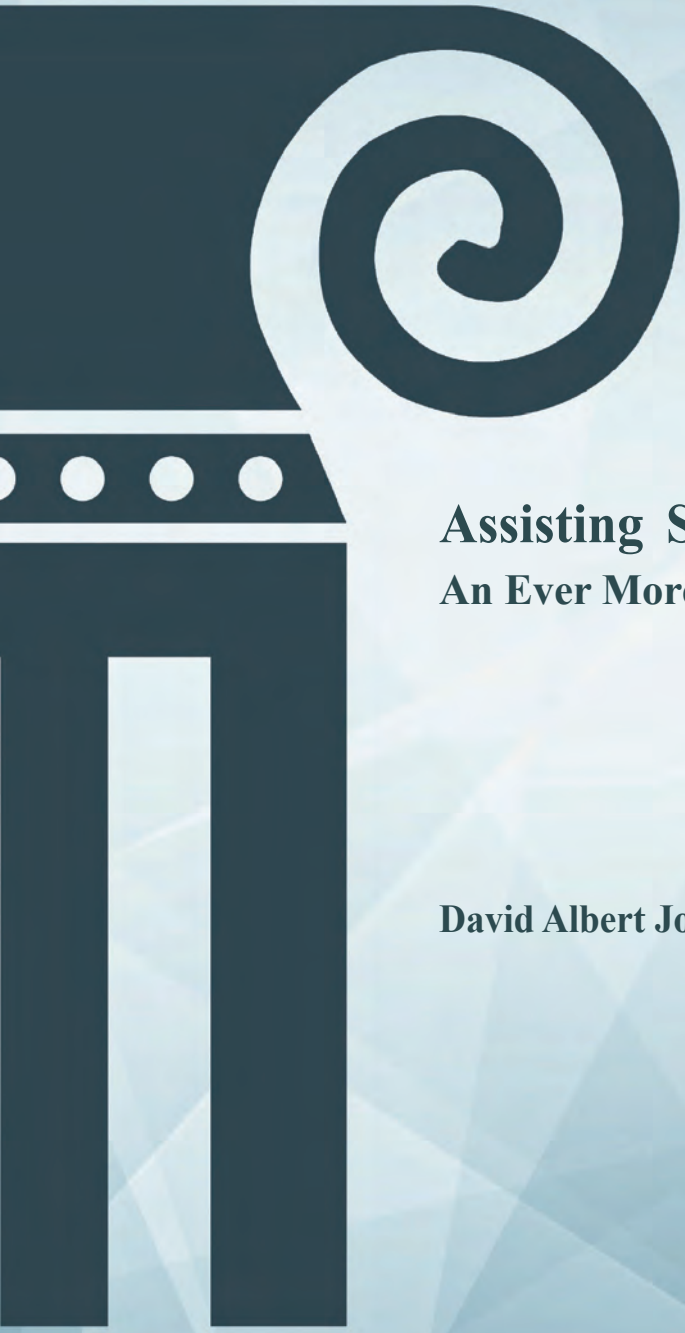

Assisting Suicide

An Ever More Dangerous Bill

David Albert Jones

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I
Introduction[1]

The Terminally Ill Adults (End of Life) Bill, which allows other people to help those eligible under the bill to end their own lives, had its Second Reading in the House of Commons late last year.[2]

It was considered in a Public Bill Committee early in 2025 during a number of sittings between late January and late March, when it was significantly amended.[3]

The House of Commons had its first opportunity to consider the Bill as amended in the Public Bill Committee and to debate a number of amendments on 16 May, 13 and 20 June, the Bill passing its Third Reading on 20 June with a significantly reduced majority, 314 to 291, and no longer commanding the support of a majority of the whole House.[4]

Now, during the Bill's passage through the House of Lords, peers will scrutinize the Bill, identify its weaknesses and consider the fundamental question of whether the Bill is safe to implement in practice.

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[1] This 2nd edition updates and revises an earlier edition published by Politeia in June 2025. It follows the earlier analysis, *How Safe the Safeguards? The Terminally Ill Adults (End of Life) Bill* (2024), https://www.politeia.co.uk/how-safe-safeguards/

[2] These debates, on Second Reading, 29 November 2024, at the Public Bill Committee and the Department of Health and Social Care and Ministry of Justice documents, and other publications are available on the UK Parliament website for the Bill https://bills.parliament.uk/bills/3774/publications. They will be discussed in later chapters.

[3] https://publications.parliament.uk/pa/bills/cbill/59-01/0012/PBC012_Terminally_Ill_Adults_1st-29th_Compilation_26_03_2025_REV.pdf

[4] These debates can be found in Hansard as that for 16 May is not reported on the parliamentary bills website.
16 May https://hansard.parliament.uk/Commons/2025-05-16/debates/6B16FAB4-8443-4720-B234-B20CE79BFAE6/TerminallyIllAdults(EndOfLife)Bill
13 June https://hansard.parliament.uk/Commons/2025-06-13/debates/AD5D60DD-BDA2-4E12-A854-E2A356E1CF58/TerminallyIllAdults(EndOfLife)Bill
20 June https://hansard.parliament.uk/Commons/2025-06-20/debates/525F3344-9DEB-4821-8F8D-01BE7B5E80B0/TerminallyIllAdults(EndOfLife)Bill

II
Second Reading: 'A vote to continue the debate'[5]

The debate on Second Reading on 29 November 2024 lasted 4 hours and 30 minutes with 90 MPs speaking (not counting the Speaker and Deputy Speakers) and 605 voting.[6] It covered many themes that had been raised in previous debates in Parliament on this topic and also included personal experiences of MPs and of their constituents.

In relation to what was new and specific to the debate over the Terminally Ill Adults (End of Life) Bill, two themes were prominent: The first of these was the unique set of safeguards in the Bill, and especially judicial oversight. The second was the opportunity for future scrutiny and amendment of the Bill, if it were allowed to progress.

The Bill was presented as offering 'the strongest set of safeguards and protections in the world'.[7] There were said to be 'multiple layers of checks and safeguards… embedded in the Bill'.[8] Among these, one was highlighted as unique and this was the role of the High Court. The Bill involved, 'a thorough and robust process involving two doctors and a High Court judge… The court must speak to one of the doctors and can hear from anybody else they deem necessary.'[9]

Not all were convinced by the role given to the courts. Two Members cited Sir James Munby, former family division president who had argued that the Bill 'falls lamentably short of providing adequate safeguards'.[10] It was also stated that 'many eminent judges have made the point that it will overwhelm the family courts if the test were applied properly'.[11]

[5] Hansard Vol. 757 Col. 1021 (statement by the Bill's sponsor, Kim Leadbeater MP in opening the Second Reading debate. References to House of Commons statements by MPs will henceforth give the MPs name.)
[6] Hansard Vol. 757 Cols. 1084-1087: Division 51: held on Friday 29 November 2024
[7] Hansard Vol. 757 Col. 1017 (Kim Leadbeater MP)
[8] Hansard Vol. 757 Col. 1017 (Kim Leadbeater MP)
[9] Hansard Vol. 757 Col. 1019 (Kim Leadbeater MP)
[10] Hansard Vol. 757 Col. 1039 (Rachel Maskell MP) see also Hansard Vol. 757 Col. 1029 (Diane Abbott MP)
[11] Hansard Vol. 757 Col. 1028 (Danny Kruger MP)

The predominant theme, however, was that the proposal for judicial involvement was a significant reassurance in the Bill not found in other jurisdictions.

One MP 'genuinely believe[d] … [the role of] two doctors and a judge massively reduce[d] the risk of coercion'.[12] Another thought it was 'right for this Bill to require two doctors and a judiciary review, because this is new legislation and we must be sure that it is safe'.[13] For another, a 'sign-off by two independent doctor [combined with] judicial oversight and a period of reflection … means there would be robust mechanisms to protect the most vulnerable.[14]

A second notable theme that was the framing of the Second Reading vote as one to enable further discussion. The Bill had not undergone the level of prior scrutiny that a Government Bill would have received. However, while conceding this, supporters presented the need for further scrutiny as an argument in favour of voting for the Bill at Second Reading. The Bill's proposer and architect, sought to reassure MPs that:

> a vote to take this Bill forward today is not a vote to implement the law tomorrow. It is a vote to continue the debate. It is a vote to subject the Bill to line-by-line scrutiny in Committee, on Report and on Third Reading…[15]

To give reassurance that there would be adequate opportunity for such scrutiny, not usually available for a Private Member's Bill, the proposer and sponsor would move a motion to allow the Bill Committee to take external evidence. She was minded

> to move a motion that gives the Bill Committee the power to take oral and written evidence in order to ensure that a thorough approach continues to be taken. That is not normal procedure for a Private Member's Bill, but I think that that is the right thing to

[12] Hansard Vol. 757 Col. 1013 (Alicia Kearns MP)
[13] Hansard Vol. 757 Col. 1070 (Dr Simon Opher MP)
[14] Hansard Vol. 757 Col. 1074 (Peter Bedford MP)
[15] Hansard Vol. 757 Col. 1021 (Kim Leadbeater MP)

> do. I also reassure colleagues that the Bill Committee will meet over a number of weeks, meaning that there is ample time for full consideration of the details of the Bill, including amendments. The Committee will be representative of the views and make-up of the House.[16]

This argument had real traction among MPs, many of whom were sympathetic to the principle of allowing assisted dying but had doubts about whether the provisions of the Bill would be effective safeguards in practice. For at least some who were in two minds, it shifted the default:

> To that end, I want to be up front: I will be voting for the Bill today, because I want this conversation to continue… I want to keep grappling with the detail until I get to Third Reading, when I might reserve the right to vote no.[17]

> I will support the Bill on Second Reading if there is a guarantee of sufficient scrutiny… If Committee scrutiny cannot make the Bill robust, I will reconsider my support in future votes.[18]

> We all have doubts, but surely today's vote is simply to let it go to the next stage. The final decision on Third Reading is the critical one.[19]

> … if necessary they should reject the Bill on Third Reading, but to stop it now is to stop the conversation entirely.[20]

> Today, we can vote for that in the sure knowledge that if the Bill passes its Second Reading, it will undergo further intense scrutiny.[21]

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16 Hansard Vol. 757 Col. 1020 (Kim Leadbeater MP)
17 Hansard Vol. 757 Col. 1040 (Layla Moran MP)
18 Hansard Vol. 757 Col. 1068 (Liz Saville Roberts MP)
19 Hansard Vol. 757 Col. 1022 (Andrew George MP)
20 Hansard Vol. 757 Col. 1071 (Dr Luke Evans MP)
21 Hansard Vol. 757 Col. 1066 (Lizzi Collinge MP)

The final vote was 330 in favour to 275 against.[22] MPs will have been influenced by many different arguments before voting. Nevertheless, the debate shows that the involvement of 'two doctors and a High Court judge' was widely regarded as an important safeguard. A number of MPs also voted precisely in order to give the Bill the further scrutiny it required, reserving the right to vote no at Third Reading depending on the outcome of that process. Their Second Reading vote was expressly 'a vote to continue the debate'.

[22] Hansard Vol. 757 Cols. 1084-1087: Division 51: held on Friday 29 November 2024

III
Public Bill Committee: 'Negatived on division'[23]

The Public Bill Committee met from 21 January 2025 to 25 March 2025, a committee which is supposed to reflect not only the political balance in the House but 'should also reflect balance of views on the bill' – the proposer of the Bill submitting a list of MPs who wish to sit on it to a selection committee.[24] That threshold was not in fact reflected in that a greater proportion of Committee members favouring the Bill was appointed, (65.2 per cent, that is, 15 to 8 in Committee votes) than had supported it at Second Reading, (54.5 per cent, 330 to 275).[25] Furthermore, whereas the Government has repeatedly stated that it is neutral on the Bill,[26] with divisions in the cabinet a matter of public knowledge, both ministers on the Committee were in favour and both voted with the sponsor on every division.

There was also a significant imbalance in the selection of witnesses, unlike the process in a Government Bill and little openness to change this selection. An amendment to invite a representative of the Royal College of Psychiatrists, was 'negatived on division',[27] a decision only reversed

[23] Parliamentary terminology for rejection of a motion following a vote.

[24] Public Bill Committee Terminally Ill Adults (End of Life) Bill PBC (Bill 012) 2024-2025 Compilation of All Debate sittings (2 Apil 2025) https://publications.parliament.uk/pa/bills/cbill/59-01/0012/PBC012_Terminally_Ill_Adults_1st-29th_Compilation_26_03_2025_REV.pdf The rules for the process and membership stipulate the following for the proposer: you will be in charge of giving them [the committee selecting the make-up] a list of names of MPs who are putting them '…selves forward. This list must reflect the party balance in the House and should also reflect a balance of views on the bill. …You will be expected to take part in debates in the committee on your bill, presenting arguments for why it should become law, and debating amendments suggested by you or other MPs. You may also need to act in a similar way to a whip, making sure that MPs are present, that there is quorum, and that your supporters are available if there are votes on amendments or clauses in the bill….' https://guidetoprocedure.parliament.uk/articles/TN2QnUGj/public-bill-committees-for-private-members-bills

[25] See for example Divisions No. 2, No. 3, No. 4, and No. 5 (PBC Bill 012, cols 348, 434, 434, 435), note that one member, Jack Abbott MP, voted against at Second Reading but voted with the sponsor of the Bill the majority of the time on the Committee. Even discounting this, the Committee underrepresented those against the Bill at Second Reading.

[26] See for example Hansard Vol. 757 Col. 1082 (The Parliamentary Under-Secretary of State for Justice, Alex Davies-Jones MP), PBC (Bill 012) 2024-2025. Col. 184 (The Minister for Care, Stephen Kinnock MP), PBC (Bill 012) 2024-2025, Col 267 (The Minister of State, Ministry of Justice, Sarah Sackman MP).

[27] PBC Bill 012, Col. 23 Division No. 1.

after public criticism. Most witnesses selected were already known to be in favour of a change in the law. Evidence from jurisdictions with experience of such laws was also selective. No witness from the states with problematic arrangements, Canada and Belgium was called whereas six witnesses were invited from Australia,[28] none critical of Australian practice.

Witnesses from Canada and Belgium were excluded on the grounds that the law in these places differs from the provisions in the Bill. However, the law in Australia also differs from the Bill in important respects. No Australian jurisdiction limits 'voluntary assisted dying' [VAD] to self-administration, all allow euthanasia (like Canada and Belgium). None limit eligibility only to people with a life expectancy of 6 months or less.[29]

It is also important to note that the law and practice of VAD in Australian is in flux. As successive jurisdictions have followed the VAD law in Victoria, later jurisdictions have abandoned more and more of its safeguards. For example, Victoria included eligibility at 6 months life expectancy with an exception of 12 months only for people with neurodegenerative diseases, Queensland extended this to 12 months for all patients, and the Australian Capital Territory has no timeframe for expectation of death.[30] Australian law is coming to resemble the law in Canada.[31]

In February 2025, the Government in Victoria announced its intention to amend its own law to follow this expansive trend.[32] Australia is a classic

[28] On the reliance on Australian witnesses see D.A. Jones, 'Wrong Side of the World: The Misplaced Reliance on Australia in the UK Debate on "Assisted Dying"', Oxford: Anscombe Bioethics Centre, 2024. https://www.bioethics.org.uk/research/euthanasia-assisted-suicide-papers/wrong-side-of-the-world-the-misplaced-reliance-on-australia-in-the-uk-debate-on-assisted-dying-professor-david-albert-jones/

[29] For this reason no Australian jurisdiction was chosen as a 'comparable jurisdiction' in the Government's Impact Assessment. See Department of Health and Social Care / Ministry of Justice Terminally Ill Adults (End of Life) Bill (as amended in the House of Commons Public Bill Committee): impact assessment (14 May 2025), para. 8. https://publications.parliament.uk/pa/bills/cbill/59-01/0212/TIABImpactAssessment.pdf

[30] See Victoria VAD Act 2017, s. 9 (4); Queensland VAD Act 2021, s. 10(1)(a)(ii); ACT VAD Act 2024, s. 11 (6).

[31] That is, to the Law in Canada as it was in 2016, when there was an eligibility requirement that natural death be 'reasonably foreseeable' but without specifying a timeframe.

[32] Mary-Anne Thomas, Victoria Minister for Health 'Voluntary Assisted Dying Laws Still The Compassionate Choice.' Media release. Thursday, 20 February 2025. https://www.premier.vic.gov.au/sites/default/files/2025-02/200225-Voluntary-Assisted-Dying-Laws-Still-The-Compassionate-Choice.pdf

example of a 'slippery slope' in action.[33] A shift from prioritising 'safety' to prioritising 'access' is leading Australia away from the model found in the United States and towards the model found in Canada or Belgium. This is why the Public Bill Committee needed to hear also from witnesses from Canada or from Belgian, and needed to hear from witnesses critical of current practice.

Some of the misleading oral evidence was counteracted by written evidence.[34] However, the Committee did not consider the written evidence in any systematic way. Submissions were published on the website, but written evidence was considered in Committee only when raised by a member of the Committee. There was no report by the Committee giving an overview of the oral and written evidence it received.

The Bill was amended significantly during this process but this was overwhelmingly as a result of amendments proposed by the sponsor, not as a result of amendments coming from other Members of Parliament. Kim Leadbeater proposed 157 amendments of which 7 were not selected by the chair and 150 were agreed.[35] All other Members of Parliament proposed 420 amendments of which 39 were agreed without division and 2 were agreed after division. Over 90 per cent were not called, not selected, not moved, withdrawn or negatived. Of those proposed by other MPs and subject to vote in Committee, only 2 out of 92 were agreed or added.[36] The other 90 were 'negatived on division'. Many proposed amendments, and most of the 90 which were 'negatived on division', embodied reasonable and good faith proposals for improving the safety of the Bill. For example, under the current law it is an offence to 'encourage or assist suicide'.[37] The Bill permits a doctor to provide a lethal

[33] See D.A. Jones, 'Wrong Side of the World', pp.6–10.

[34] For example the submission TIAB27 by X. Symons and B. Tobin of the Plunkett Centre for Ethics https://publications.parliament.uk/pa/cm5901/cmpublic/TerminallyIllAdults/memo/TIAB27.htm, or the submissions TIAB245 by R. Clark, former Attorney-General and MP Victoria. https://publications.parliament.uk/pa/cm5901/cmpublic/TerminallyIllAdults/memo/TIAB245.htm and TIAB254(a) https://publications.parliament.uk/pa/cm5901/cmpublic/TerminallyIllAdults/memo/TIAB245(a).htm

[35] Terminally Ill Adults (End of Life) Bill (Committee Stage Decisions) 25 March 2025 https://publications.parliament.uk/pa/bills/cbill/59-01/0012/amend/terminally_ill_adults_rpro_pbc_0325.pdf

[36] Amendment 535 (Sarah Olney MP) and New Clause NC18 (Liz Saville Roberts MP) both of which concern regulations for Wales.

[37] Suicide Act 1961 as amended 2009, s. 2(1).

drug to 'assist' a patient to end their own life. An amendment proposed that the doctor should nevertheless not 'encourage' a patient to end their own life.[38] This would have maintained the current law on encouragement of suicide, but it was negatived by the Committee.[39]

Again, there was considerable debate on the Committee,[40] and in written evidence,[41] about the adverse impact of the Bill on suicide prevention. An amendment was proposed to ensure that patients were 'not seeking assistance to end their own life because of an impairment of judgment arising from a mental disorder or other condition'.[42] However, this again was 'negatived on division'.[43]

The members of the Public Bill Committee are to be commended on the time given to this stage of the process, not least on the final day of debate which began at 9.25am[44] and was not concluded until the Committee rose at 12.26am the following day.[45] Nevertheless, neither the balance of the process nor the level of scrutiny was equivalent to that for a Government Bill.

There was no extended preparation process with engagement with the public and with experts prior to drafting legislation. The oral evidence was very selective and there was no systematic consideration of written evidence.

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[38] Amendment 82 (Rebecca Paul MP) see PBC (Bill 012) 2024-2025. Cols. 381ff.
[39] PBC (Bill 012) 2024-2025. Col. 434, Division No. 4.
[40] See for example PBC (Bill 012) 2024–2025. Col. 160–161, 466–467.
[41] Those focusing on the issue of suicide prevention included submissions by Gillet (TIAB04), Paton (TIAB125), Kelly (TIAB176) Bow (TIAB185), and Ibbett (TIAB434). Other submissions that contain interesting observations on this issue, some from personal experience, include Keene (TIAB46), House (TIAB55), the Royal College of Psychiatrists (TIAB67), the Pathfinders Neuromuscular Alliance (TIAB84), Denno (TIAB99), the Other Half (TIAB104), the Association for Palliative Medicine of Great Britain and Ireland (TIAB114), Herx et al. (TIAB130), Pembroke and Atkinson (TIAB137), Shaw (TIAB140), Ohlsen (TIAB143), Lyon (TIAB165), Wilson (TIAB231), Watt (TIAB263), Tan (TIAB241), Clark (TIAB245) (TIAB245(a)), Jeffrey, (TIAB254), Ibbett (TIAB270), Anon (TIAB274), Leeder (TIAB283)*[listed in index as TIAB285], Hopkins. (TIAB288), Granet (TIAB290), Reynolds (TIAB295), VISION consortium (TIAB304), Ashenfelter (TIAB306), Murray (TIAB308), Dempsey (TIAB323), Buckley (TIAB326), Trussell (TIAB353), Doerflinger (TIAB360), Thomas (TIAB368), Bien et al. (TIAB400).
[42] Amendment 363 (Wera Hobhouse MP) see PBC (Bill 012) 2024-2025. Cols. 841ff.
[43] Division No.35.
[44] PBC (Bill 012) 2024–2025. Col. 1371
[45] PBC (Bill 012) 2024–2025. Col. 1546.

Detailed examination of clauses was considered by only 23 Members of Parliament and very few of the amendments which would have improved the safety of the Bill were accepted. The great majority of changes were made not at the initiative of the House but at the initiative of the sponsor.

IV
The Bill as Amended: Missing safeguards

The question at Report stage and Third Reading is the pragmatic one of whether the provisions of the Bill, as amended, could be implemented safely and effectively. Does the Bill provide adequate safeguards to prevent serious abuses such as deaths through coercion, or the death of people who could have had years of life ahead of them?

Physician encouragement. The Bill was amended extensively in Committee stage. However, these amendments have not addressed the key concerns raised during the debate. The Bill as amended would still allow doctors pro-actively to suggest to patients that they consider ending their lives.[46] Indeed, the Bill would allow doctors to encourage patients to take this option, as they might encourage a patient to accept a clinically-indicated and cost-effective medical treatment. The Bill as amended is unsafe for patients who would be vulnerable to undue influence by a doctor.

Misuse of the Mental Capacity Act. Another key issue is the use of the Mental Capacity Act 2005, with its presumption of capacity,[47] as a test for eligibility in the Bill.[48] This test would not prevent people who were suicidal and were suffering from a treatable mental illness from being offered the means to end their lives. This problem can be seen in the way the Mental Capacity Act 2005 defers to the Mental Health Act 1983 in relation to the compulsory treatment of a suicidal patient.[49] A minimal level of capacity is not sufficient warrant for a decision to end your life. The Royal College of Psychiatrists, amongst others, have strongly criticised this use of the

[46] Terminally Ill Adults (End of Life) Bill (as amended in Public Bill Committee), Clause 5 (2).
[47] Mental Capacity Act 2005, s. 1(2).
[48] Terminally Ill Adults (End of Life) Bill (as amended in Public Bill Committee), Clause 3.
[49] Department for Constitutional Affairs *Mental Capacity Act 2005: Code of Practice* London: TSO, 2007, chapter 13. https://assets.publishing.service.gov.uk/media/5f6cc6138fa8f541f6763295/Mental-capacity-act-code-of-practice.pdf

Mental Capacity Act in the Bill.[50] The Bill as amended is unsafe for people with mental illness.

'Terminal' illness – What definition? A related issue is the way that terminal illness is defined. It is possible that someone who could live for many years with effective and available treatment to be classed as 'terminally ill' under the Bill as a result of refusing treatment. This is a pattern in Canada where patients have been recommended to refuse treatment in order to become eligible for 'medical assistance in dying'.[51] This issue has been highlighted in the debate in relation to anorexia.[52] Anorexia is not a terminal condition. It is treatable mental health condition. However, without effective treatment it can lead to catastrophic physical decline and death. Nothing in the Bill as amended would prevent the Bill being used to provide someone with anorexia who was forgoing treatment with the means to end their life. This is not a speculative risk but is one that has been realised in practice in Oregon, Colorado and several other jurisdictions.[53] The Bill as amended is unsafe for people with eating disorders.

Elder abuse, coercion? It should be acknowledged that there have been positive amendments that have mitigated some of the flaws in the Bill as introduced, for example stipulating that the Secretary of State 'must' rather than 'may' provide regulations about training,[54] and an assessing doctor

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[50] Written evidence submitted by the Royal College of Psychiatrists (TIAB67), paras. 9–11. https://publications.parliament.uk/pa/cm5901/cmpublic/TerminallyIllAdults/memo/TIAB67.htm See also Press release: 'RCPsych comments on vote for assisted dying Bill in England and Wales' (29 November 2024) https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2024/11/29/rcpsych-comments-on-vote-for-assisted-dying-bill-in-england-and-wales

[51] B. Pesut et al. 'Navigating medical assistance in dying from Bill C-14 to Bill C-7: a qualitative study.' *BMC health services research* 21 (2021): 1–16, page 10. See Jones 'How Safe the "Safeguards"?' Politeia, p. 6.

[52] PBC (Bill 012) 2024-2025. Col. 139ff (Chelsea Roff oral evidence) also written evidence submitted by C. Roff (Eat Breathe Thrive, UK), et al. TIAB 54 https://publications.parliament.uk/pa/cm5901/cmpublic/TerminallyIllAdults/memo/TIAB54.htm
Supplementary written evidence submitted by C. Roff, C. Cook-Cottone, and A. Ayton TIAB131 https://publications.parliament.uk/pa/cm5901/cmpublic/TerminallyIllAdults/memo/TIAB131.htm

[53] C. Roff and C. Cook-Cottone, 'Assisted death in eating disorders: a systematic review of cases and clinical rationales.' *Frontiers in Psychiatry*, (2024) 15. Available at: https://www.frontiersin.org/journals/psychiatry/articles/10.3389/fpsyt.2024.1431771/full

[54] Amendment 186 (Kim Leadbeater MP), Bill as amended, Clause 7 (6)

'must' rather than 'may' refer on to a specialist if they have doubt as to the capacity of the person being assessed.[55] Another positive change is the requirement that mandatory training includes 'training in respect of domestic abuse, including coercive control and financial abuse'.[56] Nevertheless, such mitigations do not resolve the underlying problem that domestic and elder abuse are both very common and that coercion is very difficult to detect. There are no tools that can reliably detect all or even most elder abuse.[57] If the law passed some people would die through coercion. The Bill as amended is unsafe for people in abusive or coercive relationships.

Promoting 'access' v promoting safety. Other amendments, while well intended, bring their own risks. In the amended Bill, someone with a learning disability, a mental disorder, or autism would be supported by an 'independent advocate'.[58] However, whether this would lead to greater protection depends on how this person understands their role. The Government's Equality Impact Assessment makes no reference to the advocate providing enhanced protection for the life of the vulnerable person. The role is rather to provide 'support and advocacy on end of life care, including access to assisted dying'.[59] There is a tension, that should be acknowledged, between promoting 'access' and promoting safety. It is far from clear that this amendment will make the Bill safer for vulnerable people.

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[55] Amendment 6 (Daisy Cooper MP) Bill as amended, Clause 11 (6)(b)

[56] Amendment 20 (Jess Asato MP) Bill as amended, Clause 7(9)

[57] A.H. Sohal, G. Feder, K. Boomla et al. 'Improving the healthcare response to domestic violence and abuse in UK primary care: interrupted time series evaluation of a system-level training and support programme.' *BMC Med* 18, 48 (2020). https://doi.org/10.1186/s12916-020-1506-3 R. Turner, P. Glue and Y. Barak, 'Effects of changing criteria on improving interrail assessment for elder abuse: analysis of a national dataset from Aotearoa New Zealand.' *BMJ Open* 2024;14:e081791. doi:10.1136/bmjopen-2023-081791 https://bmjopen.bmj.com/content/bmjopen/14/7/e081791.full.pdf

[58] New Clause (Dr Marie Tidball MP) Bill as amended, Clause 20

[59] Department of Health and Social Care / Ministry of Justice Terminally Ill Adults (End of Life) Bill (as amended in the House of Commons Public Bill Committee): Equality impact assessment (14 May 2025), p. 11. https://publications.parliament.uk/pa/bills/cbill/59-01/0212/TIABEqualityImpactAssessment.pdf

'Impartial judges have been replaced by a voluntary panel'.[60] The biggest change in the Bill as amended is the removal of the role of the High Court and its replacement by a system of review panels[61] which would include a lawyer, a social worker, and a psychiatrist, and would be overseen by the office of the Voluntary Assisted Dying (VAD) Commissioner.[62]

The VAD Commissioner's office would be an arms-length body (a 'quango') which would be responsible for oversight of the VAD Service. The Government's Impact Assessment estimates that this arms-length body would cost around £10 million a year even before factoring in the cost of the panels.[63]

This change, without doubt, represents a weakening of the Bill. These review panels would neither have the status nor command the public trust of the court system. Rather than determinations by existing judges, the panels would recruit from a pool of people recruited with a special interest in this issue. Inevitably this would result in bias. This can be illustrated from other jurisdictions. A case in Belgium, which was considered by the European Court of Human Rights,[64] concerned a practitioner Dr Wim Distelmans who was both well known for his involvement in controversial euthanasia deaths and was also the head of the euthanasia review board. Part of the legal complaint was that Distelmans did not recuse himself when reviewing a death which he had brought about. Again, in Australia, the VAD review

[60] Hansard Volume 767. Terminally Ill Adults (End of Life) Bill. debated on Friday 16 May 2025, Col. 692 (Carla Lockhart MP) https://hansard.parliament.uk/Commons/2025-05-16/debates/6B16FAB4-8443-4720-B234-B20CE79BFAE6/TerminallyIllAdults(EndOfLife)Bill

[61] Bill as amended, Clause 15, Schedule 2

[62] Bill as amended, Clause 4, Schedule 1. Note the language of Voluntary Assisted Dying (VAD) is drawn from Australian law and practice. This is of concern given that VAD in Australia encompasses euthanasia, has wider eligibility criteria, and has seen safeguards abandoned or weakened significantly in only 5 years.

[63] Impact Assessment, para 228: 'This IA estimates that the **cost of the Voluntary Assisted Dying Commissioner, and their office**, would be approximately **£10m per year**.' (Bold in the original).

[64] Mortier v Belgium (78017/17)

boards both in Victoria[65] and in Western Australia[66] have lobbied their respective Governments to expand the law and remove safeguards.

The Bill as amended has also become more ambiguous as to who would be responsible for the VAD Service, whether it would be delivered through the NHS or whether private healthcare providers or other external organisations might be commissioned to deliver it.[67] One of the amendments which was 'negatived on division' in the Public Bill Committee was a prohibition of doctors advertising VAD services.[68] The possibility of interaction between external providers, campaign organisations, and review panels further weakens the impartiality of the review panel system in comparison to the court system contained in the Bill as introduced.

* * *

In sum, the Bill as Amended by the Public Bill Committee retains many of the flaws in the Bill as introduced,[69] and while some amendments mitigate a few of the risks posed by the Bill, the Bill remains unsafe. Furthermore, the most prominent change, the dropping of the role of the High Court, represents a significant weakening of the safeguards promised in the Bill as introduced. There were already flaws in the Bill, but it has emerged from Committee less safe than it was at Second Reading.

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[65] Victoria Minister for Health Media release 20 February 2025: 'In response to this important review, feedback from the community and *the recommendations made by the Voluntary Assisted Dying Review Board*, the Labor Government will rewrite legislation to improve access to VAD, bringing it in line with other jurisdictions' (emphasis added).

[66] Voluntary Assisted Dying Board Western Australia Annual Report 2022–23, pp. 53–37 https://www.health.wa.gov.au/~/media/Corp/Documents/Health-for/Voluntary-assisted-dying/VAD-Board-Annual-Report-2022-23.pdf

[67] Bill as amended, Clause 38, compare with Bill as introduced Clause 32 (title).

[68] New Clause 9 (Dame Harriet Baldwin MP). Division No. 99. This issue is returned at Report stage as New Clause 14 (debated 13 June 2025) sponsored by Kim Leadbeater MP and was agreed after a division on an amendment. The chief difference is that the new clause will give the Secretary of State the task of producing regulations to prohibit advertising, with exceptions.

[69] As set out in Jones 'How Safe the "Safeguards"?' Politeia, 2024.

V
Impact Assessments: 'A potential reduction in spend'[70]

On 2 May 2025 the Department of Health and Social Care and the Ministry of Justice produced an Impact Assessment,[71] an Equality Impact Assessment,[72] and a Human Rights Memorandum.[73] These documents were not only too late for the Committee Stage. They were released with minimal publicity the day after the local elections (a Friday when governments wish to 'bury' something potentially difficult for them) just as the Bank Holiday weekend got underway.[74] Predictably, the documents received relatively little attention ahead of the first Report stage debate on 16 May 2025.

The 'Impact Assessment' (IA) is primarily an assessment of the potential financial costs and cost reductions of implementing the Bill.[75] For its estimation of the potential number of deaths under the Bill, the IA focuses almost exclusively on the United States, with little consideration of New Zealand, and still less of Australia or Canada. However, the United Kingdom is closer to these Anglophone Commonwealth countries in its healthcare systems and societal norms than it is to the United States. On the model of New Zealand, Australia, and Canada, the potential numbers seeking death under the Bill could be far higher than estimated.[76]

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[70] Impact Assessment, paras. 271,272

[71] Impact Assessment https://publications.parliament.uk/pa/bills/cbill/59-01/0212/TIABImpactAssessment.pdf

[72] Equality Impact Assessment https://publications.parliament.uk/pa/bills/cbill/59-01/0212/TIABEqualityImpactAssessment.pdf

[73] Department of Health and Social Care / Ministry of Justice Terminally Ill Adults (End of Life) Bill (as amended in the House of Commons Public Bill Committee): ECHR memorandum (2 May 2025) https://publications.parliament.uk/pa/bills/cbill/59-01/0212/TIABECHRMemorandum.pdf

[74] The impact statements now have a different date as they were revised on 14 May 2025 to correct some statistical errors.

[75] For a more detailed analysis of this document, on which the present discussion draws, see D.A. Jones 'Ending Life as Cutting Costs: The Impact of the Terminally Ill Adults (End of Life) Bill I' Oxford: Anscombe Centre, 2025 https://bioethics.org.uk/research/euthanasia-assisted-suicide-papers/ending-life-as-cutting-costs-analysis-of-the-impact-of-the-terminally-ill-adults-end-of-life-bill-i-professor-david-albert-jones/

[76] Jones 'Ending Life as Cutting Costs', p. 4, 'The upper estimate of potential numbers in the financial IA could easily be inaccurate by a factor of 5 or more.'

The main flaw in the IA is not its likely underestimation of the potential number of deaths but its decision to measure financial cost savings without measuring disbenefit, particularly given that it is a Department of Health publication, for many people synonymous with the values they identify with the NHS as promoting and restoring better health, through healthcare and treatment, and for which measures of success often are seen in terms of prolonging longevity and recovery. Yet the IA sets no value on lost life years.[77] Furthermore, the costs reductions it identifies are not because people could live with less expensive alternatives, but are because they have died. Dead people do not utilise healthcare, receive care from local authorities, or benefits from the state. The implementation of the Bill (and especially the office of the VAD Commissioner) would cost millions,[78] but the IA provides detailed estimates for how much money the NHS could save if sufficient numbers of patients end their lives early.

> **Assuming all assisted deaths occur after 2 months**, reducing the length of life by 4 months, then it is estimated that 79 per cent of the associated healthcare costs (for months 4 to 1) are no longer required… this amounts to a **potential reduction in spend of between £2.14m to £10.3m in Year 1 (which is half a year) and £13.6m and £59.6m in Year 10** (in 2025/26 prices). (Bold used in official IA, see note 78)

> **Assuming all assisted deaths occur after 5 months**, reducing the length of life by 1 month, then it is estimated that 34 per cent of the associated healthcare costs (for month 1) are no longer required… this amounts to a **potential reduction in spend of between £919k and £4.41m in Year 1 (which is half a year) and £5.84m and £25.6m in Year 10** (in 2025/26 prices). [79] (Bold used in official IA)

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[77] Impact Assessment paras 50-51, see Jones 'Ending Life as Cutting Costs', pp. 5–6.

[78] Impact Assessment, para 228: 'This IA estimates that the **cost of the Voluntary Assisted Dying Commissioner, and their office**, would be approximately **£10m per year**.' (Bold in the original).

[79] Impact Assessment paras 271–272 (bold in the original). The document also sets out what local authorities would save from unneeded care home services (297.1–2) and the 'economic transfer' in state pensions and state benefits that would not need to be paid (327.1-3). See Jones 'Ending Life as Cutting Costs', pp.6–7.

It is remarkable for a government document to provide estimates of cost savings due to deaths caused by a policy. This shows the danger that Government or Hospital Trusts could promote VAD as 'a potential reduction in spend'.

The Equality Impact Assessment ('equality IA') focuses on the impact of the Bill on those with protected characteristics. However, instead of focusing on equal protection for the lives of people with protected characteristics, the equality IA promotes the idea of 'equal opportunity' for people to end their own lives.[80] Disabled people have highlighted the experience of having their lives devalued by others and even being told that they would be 'better off dead'.[81] Providing people who face such prejudice with access to the means of ending their own life not only fails to mitigate this 'substantial disadvantage' but could lead to it having lethal consequences.[82]

The equality IA notes the prevalence of abuse of disabled people,[83] of women,[84] and of elderly people.[85] People with these characteristics are at much greater risk of ending their life under the Bill as a result of coercion by another. They are also at much greater risk of ending their lives as a result of social pressure or of barriers in accessing the means to live and thrive.[86]

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[80] Equality Impact Assessment, p. 14. For a more detailed analysis of this document, on which the present discussion draws, see D.A. Jones 'An Equal Opportunity to Live: The Impact of the Terminally Ill Adults (End of Life) Bill II' Oxford: Anscombe Centre, 2025 https://www.bioethics.org.uk/research/euthanasia-assisted-suicide-papers/an-equal-opportunity-to-live-analysis-of-the-impact-of-the-terminally-ill-adults-end-of-life-bill-ii/

[81] See for example the documentary by Liz Carr, 'Better off dead'. https://www.bbc.co.uk/programmes/m001z8wc

[82] Equality Impact Assessment, p. 7, 'This includes a requirement, where a disabled person is put at a substantial disadvantage, to take reasonable steps to avoid that disadvantage'. See Jones 'An Equal Opportunity to Live', p. 5.

[83] Equality Impact Assessment, p. 8, 'Disabled people are also twice as likely (compared to non-disabled people) to be victims of domestic abuse which includes coercive behaviour'.

[84] Equality Impact Assessment, p. 12 'Women are more likely to be victims of domestic abuse (1.6 million women compared to 712,000 men in the year ending March 2024), which can manifest as physical, emotional and sexual abuse, and can include coercive behaviour.'

[85] Equality Impact Assessment, p. 14 'Prepandemic data (2018) from the Crime Survey for England and Wales estimates 210,000 adults between 60 and 74 years experienced domestic abuse.'

[86] Equality Impact Assessment, p. 14 'The Equality and Human Rights Commission highlights that coercion or pressure may not only be applied directly via other individuals but that older persons 'may feel subtly pressured to end their lives prematurely'.

The equality IA does not emphasise these findings in its conclusion,[87] but the provisions of the Bill are a threat to the equal opportunity to live.

The Memorandum provides the Government's view on whether the Bill is compatible with the European Convention on Human Rights (ECHR).[88] It acknowledges that the Bill engages with article 2 of the ECHR, the right to life,[89] but the Memorandum fails to consider whether article 2 involves a human right to suicide prevention.[90] It fails especially to consider the right of suicide prevention of people who seek to end their own life in decisions influenced by mental illness. The Memorandum presents capacity, as defined in the Mental Capacity Act 2005, and freedom from coercion by another person, as key safeguards.[91] However, it fails to consider the Mental Health Act 1983, which is more relevant in the context of suicide. The Memorandum also neglects the great difficulty in detecting coercion and omits any consideration of coercion due to social pressure or the feeling of being a burden. In relation to its failure to safeguard the article 2 rights of people with a mental illness, the Bill may be subject to challenge under the ECHR.[92]

The Memorandum expresses the view that legal challenge under the article 14 right to non-discrimination would not lead to expansion of eligibility criteria.[93] However, similar legal challenges have led to expansion of

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[87] Equality Impact Assessment, p. 20.

[88] For a more detailed analysis of this document, on which the present discussion draws, see D.A. Jones 'A Human Right to Suicide Prevention: The Impact of the Terminally Ill Adults (End of Life) Bill III.' Oxford: Anscombe Centre, 2025 https://www.bioethics.org.uk/research/euthanasia-assisted-suicide-papers/a-human-right-to-suicide-prevention-analysis-of-the-impact-of-the-terminally-ill-adults-end-of-life-bill-iii/

[89] Memorandum, p. 9.

[90] See J. Herring, *The Right to be Protected from Committing Suicide*, Oxford: Hart Publishing, 2022, p. 135, 'a suicide involves a breach of Article 2 of the European Convention on Human Rights' . Herring is open in principle to a change in the law in the area of assisted suicide or euthanasia, but considers that the topic should start with an acknowledgement of the right of all people to suicide prevention. On this see also B.L. Mishara and D.N. Weisstub 'Is Suicide Prevention an Absolute?' *Crisis*. 2018 Sep; 39(5):313–317. doi: 10.1027/0227-5910/a000568. PMID: 30354747.

[91] Memorandum pp. 16–17.

[92] See Jones 'A Human Right to Suicide Prevention', pp.5-7, see also the legal opinion of Tom Cross KC and Ruth Kennedy https://www.11kbw.com/knowledge-events/case/tom-cross-kc-and-ruth-kennedys-legal-opinion-on-assisted-dying-bill-published/

[93] Memorandum pp. 34–35.

assisted dying laws in Canada,[94] and Colombia,[95] both of which moved from requiring an expectation of death to including people with chronic conditions. It should be notice that no European country with assisted dying currently restricts eligibility to people with a terminal illness.

The impact assessments and human rights memorandum neglect the value of life, the need to provide an equal opportunity to live, and the human right to suicide prevention. However, once these omissions are recognised, the documents serve to illustrate the profound dangers of the Bill.

[94] Introduced 2016 expanded 2021 to death not 'reasonably foreseeable': See Government of Canada: Canada's medical assistance in dying (MAiD) law. https://www.justice.gc.ca/eng/cj-jp/ad-am/bk-di.html

[95] Introduced 2015 expanded 2021 to not in the 'terminal phase' See Columbia Ministry of Health 2015 Resolution 1216, article 2: '*Enfermo en fase terminal*.'; https://derechoamorir.org/wp-content/uploads/2018/09/2015-ley-eutanasia.pdf O. Dyer, 'Colombia allows euthanasia of two people with non-terminal illness', *BMJ* 2022; 376 :o67 doi:10.1136/bmj.o67.

VI
Report stage: 'Very short on time'[96]

The first opportunity for Members of Parliament to consider the Bill as Amended in Public Bill Committee was 16 May 2025. For the great majority of MPs, this was also the first time to consider any amendments to the Bill. However, the time allotted for this consideration was 4 hours and 40 minutes[97] to consider 64 amendments,[98] i.e. less than 5 minutes per amendment.

The Speaker stated that not everyone who had indicated that they wished to speak would have the opportunity to do so. While it was 'not customary to impose a speech time limit on a Private Member's Bill,'[99] the Speaker hoped that MPs would restrict themselves to 'no more than 15 minutes in the first instance, including taking interventions'.[100] As the debate wore on the Deputy Speaker asked MPs to limit themselves to 8 minutes,[101] and later still this was cut to 5 minutes.[102] Several times the Deputy Speaker had to say 'I remind Members that we are very short of time',[103] or words to this effect. A number of MPs expressed concern about the time available for debate:

- I did want to talk about process and family, but it looks like I will not have time…[104]
- I will not be able to do justice in the time that I have…[105]
- If only I had time to go into some of the evidence I have received…[106]

[96] Hansard Vol. 767 Col. 686 (Madam Deputy Speaker, Caroline Nokes MP)
[97] From 9.25am to 2.15pm.
[98] Terminally Ill Adults (End of Life) Bill Consideration (report stage) of Bill Friday 16 May 2025: Speaker's provisional grouping and selection of Amendments https://publications.parliament.uk/pa/bills/cbill/59-01/0212/tia_report_stage_selection_and_grouping_FINAL_issued_V_1.2.pdf
[99] Hansard Vol. 767 Col. 615 (Mr Speaker, Sir Lindsay Hoyle MP)
[100] Ibid.
[101] Hansard Vol. 767 Col. 661 (Madam Deputy Speaker, Judith Cummins MP)
[102] Hansard Vol. 767 Col. 684 (Madam Deputy Speaker, Caroline Nokes MP)
[103] Hansard Vol. 767 Col. 686 (Madam Deputy Speaker, Caroline Nokes MP)
[104] Hansard Vol. 767 Col. 645 (Rebecca Paul MP)
[105] Hansard Vol. 767 Col. 648 (Dame Meg Hillier MP)
[106] Hansard Vol. 767 Col. 650 (Dame Meg Hillier MP)

- I sadly do not have enough time to speak to all of those [amendments] that I support…[107]

Some MPs were not called to speak even though they had proposed amendments that were selected for debate.[108] Those who did speak had to focus on a few key points and often, because of time constraints, did not take interventions.[109] It was thus the case that many false or misleading claims where made that were not challenged.

For example, in opposing an amendment to reserve to patients the decision to initiate a conversation about ending their life, one MP stated that, 'As doctors, we must, under our ethical obligations, give options to patients'.[110] However, the British Medical Association expressly state that the ethical obligation to give options to patients holds only for conventional medical treatments and not for the intentional ending of life.[111] Indeed, the existence of an 'obligation' to raise the option would contradict the Bill as amended, which states that 'No registered medical practitioner is under any duty to raise the subject'.[112] So this purported 'ethical obligation' cannot be a reason to reject the amendment.

Again, it was claimed in the debate that 'it could take up to two months to complete all the stages of the process as set out in the Bill'.[113] However, the minimum time for the Bill is not two months but only 9 days (a 7 days waiting period before the second assessment and panel review then a 48 hours waiting period before final request and death).[114] In Oregon, which has only one less step than the Bill, when it had a minimum waiting time of 15 days, the shortest time between first request and death was 15 days. In 2020, the law

[107] Hansard Vol. 767 Col. 664 (Florence Eshalomi MP)
[108] Such as Saqib Bhatti MP (amendment 50) or Juliet Campbell MP (amendment 23).
[109] For example Hansard Vol. 767 Col. 643 (Rebecca Paul MP); Col. 648 (Dame Meg Hillier MP); Col. 656 (Anneliese Dodds MP); Col. 664 (Florence Eshalomi MP); Col. 664 (Florence Eshalomi).
[110] Hansard Vol. 767 Col. 694 (Dr Simon Opher MP)
[111] British Medical Association 'Physician Assisted Dying' https://www.bma.org.uk/advice-and-support/ethics/end-of-life/physician-assisted-dying
[112] Bill as amended Clause 5(1)
[113] Hansard Vol. 767 Col. 638 (Kim Leadbeater MP)
[114] Bill as amended Clauses 10(3), 17(2)(b)

was amended to allow the waiting period to be waived and the shortest time between first request and death was less than a day.[115] In Western Australia, with a similar process to Oregon, and a waiting period which can be waived, the shortest time from first request to death in 2023–24 was 2 days and 25 per cent of VAD deaths occurred within 9 days of first request.[116] Clearly other jurisdictions have found ways to expedite VAD deaths and the same could happen in England and Wales if the Bill were passed.

The only amendment that received a vote on 16 May was one to ensure that employees who work for an employer (e.g. in a hospice or nursing home) who had chosen not to provide assisted dying cannot do so whilst working for that employer.[117]

It was alleged that it was 'not clear how it would work with regard to the requirement in subsection (7) for professionals to provide information'.[118]

However, it is quite clear that employers cannot oblige employees to breach the requirements of the law and there is nothing in the amendment that suggests otherwise. Again, it was suggested that 'if employers can prevent their entire workforce from participating in the provision of assisted dying, the service might not be available',[119] and even that 'the board of every healthcare trust in the country will become a battle for control between those who oppose and those who do not'.[120] Such claims are without foundation. There is nothing in the amendment that gives employers a right not to be involved, much less gives NHS trusts a right not to be involved.

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[115] Center for Health Statistics, *Oregon Death with Dignity Act 2020 Data Summary* Oregon Health Authority, Public Health Division, (16 February 2021) p. 13 https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year23.pdf

[116] Voluntary Assisted Dying Board Western Australia Annual Report 2023–24 Department of Health, (30 October 2024), pp.34–35 https://www.health.wa.gov.au/~/media/Corp/Documents/Health-for/Voluntary-assisted-dying/VAD-Board-Annual-Report-2023-24.pdf

[117] New Clause 10(a) (Rebecca Paul MP): '(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.'

[118] Hansard Vol. 767 Col. 633 (Kim Leadbeater MP)

[119] Hansard Vol. 767 Col. 703 (The Minister for Care, Stephen Kinnock)

[120] Hansard Vol. 767 Col. 686 (Kit Malthouse MP)

The amendment simply provides a mechanism for employers to have a policy on this issue in line within existing employment law without this being prevented by the 'no detriment' clause.[121] The Bill expressly gives the Secretary of State both the duty and the power to provide access to a VAD service whether through the NHS or through commissioning services.[122] This could involve compelling organisations to deliver services, but it would not necessarily do so.

While it was alleged that the amendment would not be 'workable', every jurisdiction in the United States that has passed a law to permit assisted suicide has also provided protection for institutions from the obligation to provider this on their premises or by their employees in the course of their work.[123] No one can claim that the law that has been in effect in Oregon for more that 25 years is 'unworkable', nor has any jurisdiction with institutional protections seen assisted dying prohibited within the state-run health service. On the contrary, it is the Bill that would be unworkable for many voluntary aided hospices and nursing homes with their own distinctive ethos. The amendment offered not the guarantee but the possibility of protection but regrettably, after minimal debate and on the basis of misleading claims, it was defeated by 279 to 243.[124] The Bill remains an existential threat to hospices.

Confusion was also sown in the debate by an apparent volte face by the sponsor on the topic of anorexia. Having spoken against and voted against an amendment to protect people with eating disorders at Committee stage,[125] and having not put her name to the subsequent reintroduction of this amendment

[121] Bill as amended Clause 28(2).
[122] Bill as amended, Clause 38.
[123] Oregon 1997: Death with Dignity Act. 127.885 §4.01. (4) and (5); Washington 2009, Death with Dignity Act. RCW 70.245.190 (1)d, (2); Vermont 2013 Act 39 Patient Choice and Control End of Life Act, § 5286. Colorado 2015, End of Life Options Act, 25-48-118; California 2015, End of Life Option Act. 443.15; District of Columbia Law 21-182 Death with Dignity Act, Section 11 c and d; Hawaii 2019. Our Care, Our Choice Act, §327L-19 b and c; New Jersey 2019. Medical Aid in Dying for the Terminally Ill Act, 26b 2; Maine 2019, Death with Dignity Act, § 2140. 22 B and C; New Mexico 2021. Elizabeth Whitefield End-of-Life Options Act, Section 7.
[124] Hansard Vol. 767 Cols. 712-715; Division 203: held on Friday 16 May 2025.
[125] Amendment 402 see PBC (Bill 012) 2024-2025, Col 554, Division 10.

at Report Stage,[126] and having falsely claimed that 'people with mental health conditions are not eligible for assisted dying',[127] and claimed and that the risks of the Bill to people with eating disorders were 'negligible',[128] Kim Leadbeater MP stated that she was nevertheless, 'happy to support this amendment today.'[129] However, this admission was subject to the caveat that 'some further drafting changes may be required in the other place if this amendment should pass'.[130] The appearance of agreement was thus dependent on future changes that were unspecified and would not be under the control of MPs. It was an invitation of MPs to vote for 'a pig in a poke'. In the words of the eating disorder campaigner Chelsea Roff, 'The result was confusion, smoke, mirrors, and just enough political theatre to give MPs the impression that anorexia had been dealt with, when in fact it had been deftly dodged.'[131]

The same pattern was repeated in a second day of debate on 13 June, another 69 amendments were debated, again less than 5 minutes per amendment. Eight new clauses tabled by the sponsor were agreed without division.[132] New Clause 10, which effectively concerns conscientious objection, though avoids this term, expands that section of law but without strengthening the provisions. The Bill continues to impose on doctors an obligation to provide information in order to assist someone to end their life (that is, be obliged by law to do what currently would constitute the crime of assistance in suicide).

Other new clauses seek to address dangers in the Bill but not by providing specific safeguards. Rather, they delay the problem but by requiring the Secretary of State to issue further regulations. These exemplify 'the trend of this Bill: instead of more detail being added, more powers are added.'[133]

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[126] Amendment 14 (Naz Shah)
[127] Hansard Vol. 767 Col. 638 (Kim Leadbeater MP)
[128] Hansard Vol. 767 Col. 639 (Kim Leadbeater MP)
[129] Ibid.
[130] Ibid.
[131] C. Roff 'The loophole in the assisted dying bill that no one wants to talk about' New Statesman 9 June 2025. https://www.newstatesman.com/comment/2025/06/the-loophole-in-the-assisted-dying-bill-that-no-one-wants-to-talk-about. Note also that the amendment agreed to does not prevent the Bill being applied to anorexia
[132] New Clause 10, 11, 12, 13, 14, 15, 20, 21. There was a division on an amendment to New Clause 14 but this was negatived.
[133] Hansard Vol. 768. Col. 128 (Robin Swann MP referring to New Clause 13).

The one new clause agreed on division, despite opposition from the sponsor, was a prohibition on doctors from proactively raising the issue of assisted suicide with minors, who in any case would not be eligible under the Bill.[134] It is remarkable that a division was needed to attain this safeguard.

[134] New Clause 2, division 227.

VII
Third Reading: 'A worse position today than it was on Second Reading'[135]

On 20 June 2025, MPs debated the Bill at Third Reading.

The debate was immediately preceded by votes (but not debate) on amendments to complete Report stage. Three amendments which would have excluded requests motivated by mental illness,[136] removed the problematic presumption of capacity to take one's own life,[137] and prevented the purposes of the NHS as set out in the National Health Service Act 2006, from being amended by regulation,[138] were each negatived on division.[139] Two amendments proposed by the sponsor, which concerned implementation of the law in Wales, were agreed on division.[140] One of these reversed a decision made in the Public Bill Committee.[141] Henceforth the Bill would no longer provide the Senedd with 'the power to decide for itself when it is ready to bring the Bill into force'.[142]

The Third Reading debate was different in tone to Second Reading. The sponsor sought to present the move from court scrutiny to a review panel as a strengthening of the Bill, invoking the presence of a psychiatrist on the 'multidisciplinary panel'. However, MPs were well aware that the Royal College of Psychiatrists, which is not opposed to assisted dying in principle, had come out strongly against the Bill.[143] Many also remembered

[135] Hansard Vol. 769 Col 755 (Gavin Robinson MP).
[136] New Clause 16 (Rebecca Paul MP).
[137] Amendment 24 (Daniel Francis MP).
[138] Amendment 12 (Dame Siobhain McDonagh MP).
[139] Division 249, Division 241, and Division 242 respectively.
[140] Amendment 77 (Kim Leadbeater MP), Division 243; Amendment 94 (Kim Leadbeater MP), Division 244.
[141] Amendment 94, reversing the amendment 535 as introduced at the Public Bill Committee by Sarah Olney MP. See footnote 36 above.
[142] Hansard Vol. 768 Col 1251 (Sarah Olney MP).
[143] Press release: 'The RCPsych cannot support the Terminally Ill Adults (End of Life) Bill for England and Wales in its current form' (13 May 2025). https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2025/05/13/the-rcpsych-cannot-support-the-terminally-ill-adults-(end-of-life)-bill-for-england-and-wales-in-its-current-form.

the emphasis that had been placed on judicial scrutiny at Second Reading.

After less than 10 hours to debate 133 amendments, MPs were also acutely aware of how little opportunity most had had to scrutinise the Bill. The Bill had certainly changed and expanded, but this was almost entirely as a result of successive amendments brought by the sponsor of the Bill. As stated above, many of these changes shifted the question of implementation to future regulation by the Secretary of State, so it was not clear how the Bill would work in practice. It was no longer even clear whether it would be provided within the NHS.

Many speeches at Third Reading were emotive, highlighting current examples of bad death. For the sponsor, 'Not supporting the Bill today is not a neutral act. It is a vote for the status quo. It fills me with despair to think that MPs could be here in another 10 years' time hearing the same stories'.[144] Another MP, urged by a constituent to support the Bill would do so 'because the status quo is completely unacceptable and must be reformed'.[145] Another claimed the vote was thus a 'once-in-a-generation opportunity' to change the law.[146] While impassioned, such points were about having a Bill, not whether the Bill as drafted, was safe.

But the inadequacy of the scrutiny process and the weakening of the Bill by successive amendments left MPs not more convinced of its safety but less. Despite this legislation being publicly supported by a Prime Minister with an historic majority in Parliament (a working majority of 165), the majority in favour of the Bill fell from 55 at Second Reading to 23 at Third Reading[147] with over 40 per cent of Labour MPs voting against. It no longer secured a majority of the House. Since Second Reading the House had become less reassured that this legislation was safe.

It now falls to the House of Lords to supply the serious scrutiny that was lacking in the process in the Commons. This will be a matter of considering

144 Hansard Volume 769 Col 728 (Kim Leadbeater MP).
145 Hansard Volume 769 Col 739 (Josh Babarinde MP).
146 Hansard Volume 769 Col 762 (Luke Taylor MP).
147 Hansard Volume 769 Cols 786-788, Division 245.

not only the principles but also the details of this Bill[148] and whether, in practice, it would be safe.[149]

[148] Terminally Ill Adults (End of Life) Bill (as brought from the Commons) HL Bill 112.

[149] On the constitutional propriety of the Lords preventing a Private Member Bill from progressing on the grounds that the Bill was seriously flawed or unsafe see M. Elliot 'Would it be constitutionally improper for the House of Lords to block the Assisted Dying Bill?' Public Law for Everyone 20 June 2025 https://publiclawforeveryone.com/2025/06/20/would-it-be-constitutionally-improper-for-the-house-of-lords-to-block-the-assisted-dying-bill/.

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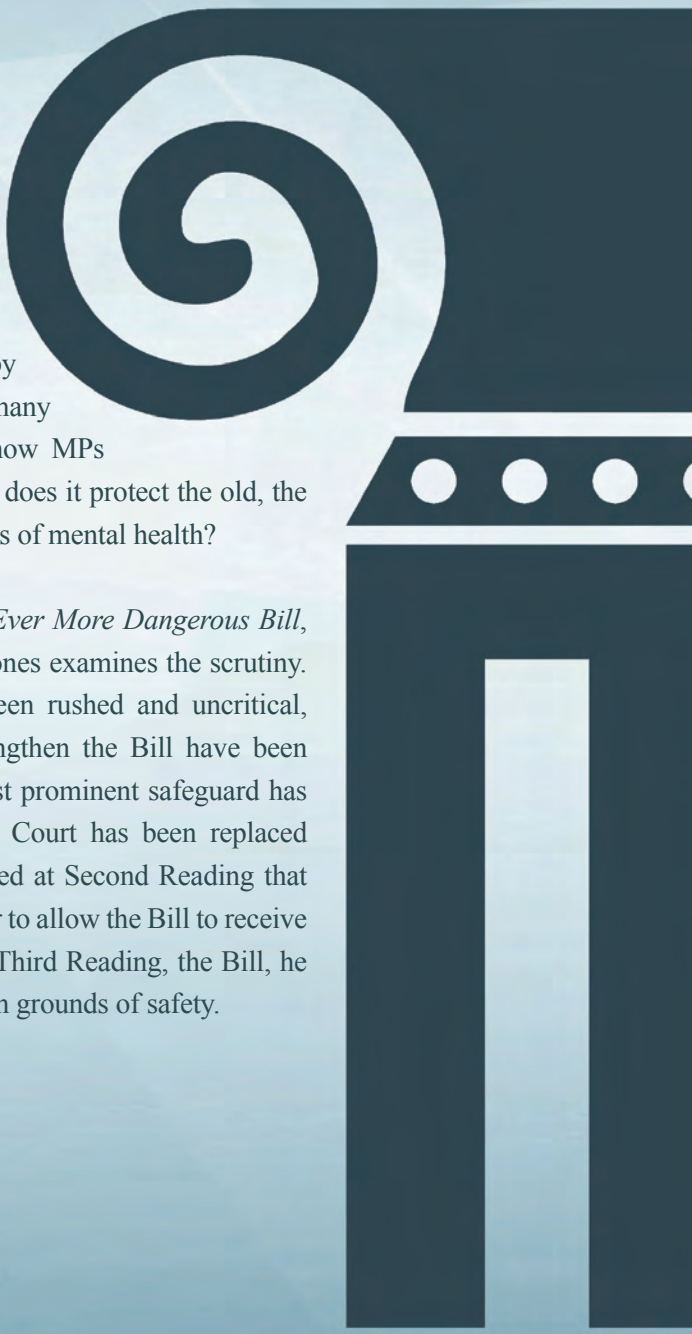

Now that the Terminally Ill Adults (End of Life) Bill awaits its final say by the House of Commons, many people are troubled by how MPs may vote. How, they ask, does it protect the old, the sick, people with problems of mental health?

In *Assisting Suicide: An Ever More Dangerous Bill*, Professor David Albert Jones examines the scrutiny. He reveals that it has been rushed and uncritical, that amendments to strengthen the Bill have been rejected, and that the most prominent safeguard has been removed: the High Court has been replaced by a quango. It was argued at Second Reading that MPs should vote in favour to allow the Bill to receive further scrutiny. Now, at Third Reading, the Bill, he says, should be rejected on grounds of safety.

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