Terminally Ill Adults (End of Life) Bill

BRIEFING – SUMMER 2026

Introduction

On 11 September 2026, Members of Parliament will once again vote on the Terminally Ill Adults (End of Life) Bill – otherwise known as the Assisted Dying Bill.

The Bill in front of MPs is **substantially unamended** from the version that ran out of time in the previous session. The sponsors of the Bill themselves tabled more than 70 amendments to it in the House of Lords, but have chosen not to include any of these changes in the Bill going back to the House of Commons – or to address any of the other issues raised by Peers and experts.

It is widely anticipated that this is because they intend that the Bill should be eligible for the process set out in the Parliament Acts 1911 and 1949, which allow a Bill that has been passed by MPs twice in the same form in two consecutive sessions of Parliament to become law, even if the House of Lords does not pass it too.

This process has never been used for a Private Member's Bill; the risks of using it **on the longest, most complex Private Member's Bill that has even been produced** are clear.

The Parliament Acts were created to ensure an elected Government with a mandate could pass its legislation. This Bill is a Private Member's Bill; it is not delivering on a manifesto commitment. What is more, because it is not being brought by the Government, there has been none of the usual work to develop and refine the proposals before putting them into legislation: no public or professional consultation, no pre-legislative scrutiny, and no minister engaging directly with MPs to hear and address their concerns.

Parliament would be setting a **brand new constitutional precedent** by passing this bill in this way. And in doing so, it would entrench in law **known risks to vulnerable people – and to the NHS –** identified by experts including medical Royal Colleges and the Equality and Human Rights Commission.

This would mean continuing to focus on assisted dying and not on much-needed improvements to palliative care that are essential for real end-of-life choice. This is despite the fact that, during the time the Bill has been under debate, the availability of that care has shrunk. Hospice UK say "nearly 60% of hospices in England have made or are considering cuts to frontline services, as financial pressures across the sector continue to intensify."

In other words, **MPs are being asked to force into law a bill that is known – even by its sponsors – to be flawed and unsafe**.

What do the experts say?

When the Bill entered the House of Lords, a special Select Committee was convened to take evidence from key witnesses. These included medical Royal Colleges, professional bodies, the Equality and Human Rights Commission, mental health and domestic abuse charities, and ministers.

None would confirm that the Bill is safe – including the Government ministers whose departments would have to deliver it if passed.

A summary of evidence given is as follows:

- **Royal College of Physicians:** *"… people [will make] these choices because of the lack of provision around good palliative care… it feels really wrong... where the disadvantaged populations are, there is service under provision and then that inequity and gap is just going to get wider and wider."*
- **Royal College of Psychiatrists:** *"Currently, needs can be identified but not necessarily met. Somebody could proceed where they may have made a different decision had those needs been met."*
- **Association for Palliative Medicine / CLADD Group:** multidisciplinary involvement comes *"too late… with the wrong people… and in the wrong form".*
- **British Association of Social Workers:** the Bill *"does not interface with adult safeguarding", creating "significant problems".*
- **Standing Together Against Domestic Abuse:** safeguards are *"not sufficient to support those who are being coerced, particularly those who will be at their most vulnerable"*
- **Royal College of Pathologists:** medical examiners are *"not trained to identify"* domestic abuse concerns and *"it is entirely possible"* they would miss them under the Bill as drafted.
- **Mind:** *"the safeguards described in the current Bill are not adequate… we feel we cannot support it in its current form".*
- **British Geriatrics Society:** *"There are inadequate safeguards within the Bill to protect older people, and there are no specific safeguards focussed on older people."*
- **National Down Syndrome Policy Group:** *"The Bill presumes the best, rather than legislates for the worst. That is the real risk with the Bill."*
- **Equality and Human Rights Commission:** the Bill *"does not really engage with the broader trends or cultural issues"* around coercion.
- **Delegated Powers and Regulatory Reform Committee (DPRRC):** a *"fundamentally flawed approach to delegated powers", with "sweeping, unspecified and unjustified"* powers and *"unknowably broad"* provisions. It allows any government to change any aspect of the NHS, including rewrite the foundational purposes of the NHS first passed into law by the Attlee Government.

What issues arose in the House of Lords?

After the Select Committee finished its work, the Lords spent a total of 14 days over six months debating the Bill in detail.

During this time, only two amendments were accepted by the sponsors. One amendment, made after significant pressure in the House of Commons, aims to ensure that eating disorders that cause a person to restrict their eating and drinking (such as anorexia nervosa) would not make a person eligible for an assisted death, but does not include eating disorders that cause physical harm in other ways.

At the end of the session, the following problems still remained – and are being carried forward in the reintroduced bill:

- **It would hand extraordinary powers to ministers to decide on what assisted dying services look like in practice.** The Bill is silent on some of the most important aspects of the new regime – such as how they are managed within the NHS and what limits there should be on how assisted dying is advertised. These questions are dealt with solely through delegated powers for ministers to make regulations later – MPs would have no power to amend these and could only vote for or against them.
- **NHS budgets will be reprioritised to fund assisted death – and we do not know what will be cut.** Minister of State for Care, Stephen Kinnock MP, confirmed to the Lords that there will need to be "reprioritisation" of funding, but said: "I am not in a position at this time to be very precise about what we might stop doing [to pay for it]".
- **Private companies will be able to profit from assisted death** – ministers could not say how much and there are no limits. Minister of State for Care Stephen Kinnock said it was "*impossible to say"* what level of profit would be acceptable.
- **The Bill could lead to cuts to palliative care.** Lord Stevens of Birmingham, former Chief Executive of NHS England, warned the House that the Bill creates a financial incentive for providers to prioritise assisted deaths over more expensive palliative care. He said it could encourag vulnerable patients choose to die early to reduce their burden and *"protect the NHS"*.
- **The definition of terminal illness is too unreliable to act as a safeguard.** Data from the Department for Work and Pensions found that 23% of patients who are not expected to live past 6 months are still alive three years later- meaning that it is impossible to say with confidence that this Bill will only apply to people who are already dying.
- **People with manageable conditions – including some eating disorders – could qualify.**
- Many illnesses that are not usually terminal and can be managed with treatment, such as Type I Diabetes or haemophilia, could meet the Bill's definition of terminal illness if a vulnerable person decided to refuse treatment. An eating disorder that causes a patient to decline for reasons other than restricting their eating and drinking – for example through organ damage from frequent vomiting – could also count.

- **People could be signed off for an assisted death without ever meeting the doctor face to face.** The Bill permits virtual assessments by live video or audio link for both doctors' assessments and Assisted Dying Review Panel hearings, which would severely limit doctors' ability to detect coercion and pressure.
- **There is no role for a person's family at any point in the process.** Family members who have vital information – for example where adult children have seen a controlling new partner enter their parent's life – may have no knowledge of the request for an assisted death until it is too late**.** And despite arguments from campaigners that the Bill will reduce the trauma experienced by the families of terminally ill people, there is nothing in the Bill to prevent them from finding out about the assisted death of a loved one only after it has happened. No arrangements need be made for them to receive bereavement support.

What did the sponsors themselves want to change?

The Bill's sponsor in the House of Lords, Lord Falconer, tabled more than 70 amendments for consideration by the House of Lords. But as the Parliament Acts plan would require MPs to pass the Bill essentially unchanged, these changes will not appear in the Bill as reintroduced.

He also accepted a number of other problems during the debates – but did not bring or accept any amendments to resolve them.

They are as follows, in the sponsor's own words:

- **Too many powers delegated to future ministers**
    - *"[The NHS clause] is currently very wide, and as the deregulation committee said, needs to be limited."*
    - *"I do recognise however the force of the DPRRC's suggestion that the regulation making powers… should be more constrained."*
- **A more robust assessment is needed to protect vulnerable young adults, and detect coercion**
    - *"I am indeed very aware of the fact that if you are 18, you may be more emotionally impulsive and more easily influenced... maybe the answer is some assurance that there is a more intense assessment for people aged between 18 and 25."*
    - *"Somewhere in the Bill, somebody has to ask why [a person wants an assisted death]... it might throw some light on circumstances that suggest classic coercion".*
- **Virtual assessments may not detect coercion and pressure**
    - *"The testimony… given of cases where remote has gone wrong have enormous power… I think the right thing to do is say something such as the norm is face to face".*

- **No clarity on what advertising of assisted dying services will be allowed:**
    - *"We are wrestling with that as well in relation to this… we are trying to come back with more detail in relation to advertising"*.

The proposed patient journey: summary of risks at each stage

1. Preliminary discussion with registered medical practitioner

- A doctor can raise assisted dying before a patient does as long as the patient is over 18.
- No exception for patients with learning difficulties, Down Syndrome, those detained for their own safety under the Mental Health Act or with a history of suicidal feelings.
- No requirement to provide equal access to palliative care or treatment before proceeding.

2. Initial request for assistance: first declaration

- Can request assisted death immediately after diagnosis of a terminal illness; no "cooling off" period.
- A proxy who doesn't know the person can sign the declarations.

3. First doctor's assessment: co-ordinating doctor

- Can be done virtually.
- No requirement for a multi-disciplinary assessment.
- No need to consult a specialist in the patient's condition.
- No need to establish whether a patient is depressed or has suicidal feelings as long as thy have capacity and a "clear, settled and informed wish" to die.
- No need for doctors to ask why the patient wants to end their life.
- No requirement for doctors to explain uncertainties of diagnosis and prognosis, or risk of a 'bad death' from lethal drugs.
- No bar on for-profit companies offering this service.
- Hospices and care homes have no legal right to opt out, and could be financially penalised for not participating.

4. Second doctor's assessment: independent doctor

- All the above issues also apply here.
- Can 'shop around' for a different second opinion if blocked by a doctor with concerns, i.e. no need to restart the process.
- If the second doctor later becomes unable or unwilling to continue to act for the patient – for whatever reason, even if they are worried about coercion – another doctor can be approached. No explanation needs to be given or recorded.

5. Panel review of eligibility (legal representative, psychiatrist, social worker)

- Panel does not have to ask questions or make further enquiries.
- Hearing from the applicant can be waived, or pre-recorded video or audio used.
- No requirement for anyone, including family, to be notified.
- No powers to investigate or ability to check safeguarding concerns with local authority.
- Families have no route to raise concerns, e.g. about coercion by another person.
- Approvals cannot be appealed – only refused applications.

6. Confirmation of request for assistance: second declaration

- Can be signed by a proxy with no knowledge of the individual.
- If the person cancels and doesn't want to proceed, there is no requirement to immediately alert other doctors, just to record it when 'reasonably practicable'.

7. Approved substance is dispensed to the co-ordinating doctor

- No regulatory requirements on face of the Bill.
- Lethal combinations and dose of drugs can be used that have not undergone any trials or MHRA approval process, unlike other medicines are regulated in the UK.
- Administration can also be via "devices", not defined or specified further.
- Studies from other jurisdiction have found that 1 in 10 people will experience vomiting, seizures, prolonged death or even re-awakening; complications and prolonged death much more likely in younger patients.

8. Provision of assistance (co-ordinating doctor remains with the person)

- No requirement for the doctor to stay in the same room when the drugs are taken.
- No provision for what should happen if the procedure fails or complications ensue.

9. Final statement made by co-ordinating doctor

- No requirement to record what happened once the drugs were taken, nor record complications.

10. Death certification

- Families will not be notified at any stage in the process and may not find out until after the death, even if there are young children involved.
- Deaths would not routinely be referred to the coroner, increasing the likelihood that deaths related to domestic abuse or medical malpractice would not be discovered.