

Terminally Ill Adults (End of Life) Bill

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See the full transcript [here](#) and [here](#)

The Terminally Ill Adults (End of Life) Bill seeks to establish a statutory framework for assisted dying in England and Wales, permitting adults with a terminal illness to request medical assistance to end their life. Its sponsors insist the Bill has ample safeguards: eligibility is restricted to those aged eighteen or above, ordinarily resident in England or Wales for at least twelve months, registered with a GP, and clinically assessed as “terminally ill”. The legislation defines this as having “an inevitably progressive disease which cannot be reversed by treatment” with a “reasonable expectation” of death “within six months”. The six-month criterion is presented as a safeguard, ensuring the scheme applies only to those at the end of life rather than to people with chronic conditions, disabilities, or mental disorders. Yet peers across the House questioned the reliability of prognostic judgements, citing clinical evidence that many people forecast to die within months can live years. Concerns were repeatedly voiced that some individuals might choose assisted dying on the basis of prognoses later shown to be mistaken, and the six-month threshold, though clear in law, is medically imprecise.

The Bill establishes a multi-layered assessment pathway. A person must first discuss their situation with a doctor, who is obliged to explain treatment and palliative options as well as the assisted-dying process. Two independent doctors must then be satisfied both of the prognosis and of the person’s capacity to make the decision. Beyond that, the Bill creates a statutory panel comprising a senior judge or King’s Counsel, a psychiatrist, and a social worker, who must also be satisfied that the application is voluntary, informed, and free from coercion. If there is doubt about mental capacity, psychiatric referral is mandated. Provisions also specify that participation is voluntary for all clinicians and staff, with explicit protection against discrimination for conscientious objection. Supporters argue this pathway provides rigorous safeguards unmatched in other jurisdictions, while critics counter that it is overly bureaucratic yet still porous in practice, with too much left to professional discretion and too much depending on future regulations.

Delegated powers were a major source of constitutional anxiety. The Delegated Powers and Regulatory Reform Committee and the Constitution Committee had already criticised the Bill for leaving excessive matters to secondary legislation. Peers described many clauses as “sweeping” or “unjustified”, including provisions that would allow Ministers to alter criminal liability or modify coroner procedures by regulation. The concern expressed across the House was that such fundamental issues of life, death, and criminal responsibility should not be left to delegated powers but set out clearly on the face of primary legislation. Several members pressed for redrafting before the Committee stage to rein in ministerial discretion.

Equally prominent were debates on palliative care and adult social care, which many peers insisted must form the real foundation of end-of-life policy. It was repeatedly argued that choice at the end of life can only be genuine if people have meaningful access to excellent palliative care and social-care support that allows them to live with dignity at home. Currently, however,

provision is patchy and underfunded. Estimates were cited of around **100,000 people a year with unmet specialist palliative needs**, alongside evidence that social-care services are overstretched and inconsistent across regions. Some peers warned that, without significant investment in both palliative and adult social care, the Bill risks creating a situation in which people request assisted death not because it is their first choice but because they lack adequate care, fear becoming a burden, or cannot secure appropriate support at home. The Bill does contain clauses requiring post-legislative review of palliative care provision, and obliges the Secretary of State to make arrangements for assisted-dying services in England (while giving Welsh Ministers a discretionary power to do so), but these were judged insufficient. Opponents insisted the sequencing was wrong: improvements to palliative and social care should precede, not follow, any legalisation of assisted dying.

The risk of coercion and subtle pressure was emphasised throughout. Although the Bill explicitly requires decisions to be voluntary and informed, several peers highlighted the difficulty of detecting covert pressure from family, carers, or even clinicians. Overseas evidence was invoked, showing many people who request assisted dying cite fear of being a burden. In the context of an overstretched NHS and fragile social-care system, speakers warned economic or emotional pressures could weigh heavily on vulnerable people. The potential for a small number of clinicians to become high-volume providers, as observed in Canada, was also raised, with calls for limits or oversight mechanisms to ensure the scheme did not generate “doctors for hire” who certify disproportionate numbers of applications.

Other safeguards attracted criticism. For example, the Bill alters the default role of coroners, removing the automatic requirement for investigation in assisted-dying cases. Opponents warned this could reduce transparency and risk concealing medical errors or malpractice. There was unease about the balance between protecting privacy and ensuring accountability. Similarly, although the Bill stipulates mental disorder or disability alone cannot qualify a person as terminally ill, several peers feared conditions such as severe anorexia or dementia might, in practice, fall within the scope once physical deterioration becomes apparent, necessitating clearer exclusions. The interplay between criminal law, coronial oversight, and medical regulation was thus highlighted as an area needing amendment.

Evidence from other nations was used to support and oppose the Bill. Supporters pointed to Oregon and Australian states, where carefully defined regimes have operated for decades without broadening eligibility. They claimed palliative care provision had in fact improved alongside assisted dying, and a regulated system is preferable to the current legal uncertainty or to people travelling abroad for traumatic deaths. Opponents countered with Canadian data showing rapid expansion in eligibility and rising numbers of deaths, insisting slippery-slope risks were real. They warned that the proportion of assisted deaths could increase significantly, despite reassurances of a low central estimate of around 1% in the UK context.

Moral and societal implications were present throughout the debate. Peers wrestled with the balance between individual autonomy and societal protection. Baroness May’s intervention was especially notable. She argued the Bill amounts to an assisted-suicide measure that risks undermining society’s stance that suicide is wrong, and people could feel pressured to die because they are old, disabled, or a burden, and raised grave concerns about coronial oversight



being curtailed. Her contribution mattered politically and symbolically: it distilled principled opposition into the language of both morality and public safety, and several later speakers engaged directly with her framing.

The debates also exposed tensions around process and parliamentary scrutiny. Some peers pressed for a Select Committee or further pre-legislative scrutiny, noting the Bill's complexity and the number of unresolved questions. Others insisted that delay is itself cruel, given that terminally ill people are dying now without access to the option. The Government maintained a position of neutrality, allowing a free vote, but some peers argued ministerial sponsorship and resources would be essential if such a far-reaching framework were to be implemented properly.

At the end of the second reading, peers voted in favour of a new select committee that would delve deeper into the implementation of the Bill, focusing specifically on: funding, the potential impact on the health and justice systems and the role of coroners and medical professionals in the process. This new committee must report back to the House of Lords by 7th November, ensuring the bill has enough time to pass into law if it should get voted through.