HOUSE OF LORDS

Terminally Ill Adults (End of Life) Bill Committee

Corrected oral evidence

Thursday 23 October 2025

10.05 am

Watch the meeting

Members present: Lord Hope of Craighead (The Chair); Baroness Berger; Baroness Berridge; Baroness Finlay of Llandaff; Lord Goddard of Stockport; Lord Goodman of Wycombe; Baroness Hayter of Kentish Town; Lord Markham; The Lord Bishop of Newcastle; Lord Patel; Baroness Scotland of Asthal; Baroness Smith of Newnham; Lord Winston.

Evidence Session No. 3 Heard in Public Questions 29 - 44

Witnesses

I: Dr Annabel Price, College Lead for the Bill, Royal College of Psychiatrists; Dr Luke Geoghegan, Policy Lead, British Association of Social Workers.

Examination of witnesses

Dr Annabel Price and Dr Luke Geoghegan.

Q29 **The Chair:** Welcome to this, the third session of our inquiry into the Terminally Ill Adults (End of Life) Bill. We are joined at this session by Dr Annabel Price and Dr Luke Geoghegan. You are both very welcome and we look forward to your evidence. We have your written statements already, but we would be grateful if, when you begin to speak, you would each briefly introduce yourselves so that we can understand exactly where you come from.

Today's session is being broadcast and a verbatim transcript will be taken for subsequent publication, and it will be sent to you so that you can check it for accuracy.

Finally, before I ask you to introduce yourselves, I should mention the list of Members' interests, which is published on our website.

Dr Price, if you would like to begin by introducing yourself, then I will pass to Dr Geoghegan.

Dr Annabel Price: Thank you. I am a consultant psychiatrist. I am the lead for assisted dying in England and Wales at the Royal College of Psychiatrists. I have been part of that working group for some time. In my clinical work, I work as a general hospital psychiatrist mainly with older people but also in palliative care. I also have a teaching role at the University of Cambridge clinical school teaching palliative care.

I will give a brief overview of our engagement with the Bill so far. As a college, we have considered the issue of assisted dying for England and Wales in depth over the last three years. In January 2023, we provided written evidence to the Health and Social Care Committee inquiry into assisted dying.

We have not and do not have a position on the principle of assisted dying or on whether Westminster should pass legislation to introduce an assisted dying service.

Ahead of the first vote in the Commons and the Public Bill Committee, we consistently highlighted concerns and questions about the reliability of consent procedures in the Bill. Before the Third Reading in the Commons, we made it clear that, owing to these practical concerns about the assessments of the co-ordinating doctor, the independent doctor and now the panel, we could not support the Bill.

Now that the Bill is before the Lords, we have been focused on aspects of the Bill that should be improved to make it safer for people with mental health need and to make it more aligned with the role and the core duties of psychiatrists. To date, we have not drafted, commented on or suggested amendments to wording on the face of the Bill. It is our view that this is a task for parliamentarians and those with legal expertise to consider after taking into account our 10 recommendations that have

already been submitted to the committee for how the Bill can be made better. I will refer to those as we go through the questions.

We have reached our views following extensive consideration by our own working group, in consultation with surveys and engagement of our members, including patient and carer representatives. We have also consulted with other organisations both nationally and internationally, and we have also taken into account international research on the mental health needs of terminally ill populations.

In our written evidence, we have limited our scope to matters within our own expertise and people with mental health needs. I understand that there may well be a focus on the panel today and we have prepared our thoughts around that, but our view is that aspects of the panel cannot be viewed in isolation from the rest of the Bill. As currently drafted, our view is that the panel does not serve the same function as a multidisciplinary team in clinical practice, and so one of our recommendations is to review the functions of the panel and to think about how a multidisciplinary assessment of need can be incorporated into the operation of the Bill.

Dr Luke Geoghegan: Good morning, Chair. Good morning, committee. I represent the British Association of Social Workers—BASW. First of all, I would like to thank all of our members at BASW who have actively contributed to our thinking on this.

BASW does not have an in-principle view on assisted dying. However, if Parliament chooses to legislate on this issue, our role is to ensure that any prospective legislation is both workable and deliverable in the interests of both the public and the profession.

With the permission of the Chair and the committee, over the course of this morning's session, I will propose six specific changes that BASW believes would improve the Bill. These cover the working of the multidisciplinary panel, the process and systems of safeguarding and mental capacity, and what we describe as early support. Part of this will be to explain how the systems and process of mental capacity and adult safeguarding operate in the real world.

BASW has also submitted a response to the Department of Health and Social Care's impact assessment, i.e. the practicalities of designing and delivering a voluntary assisted dying service. The model as currently conceived would face significant challenges in establishment and implementation. If the committee would like, I can also share the headline points of our response to the DHSC. I welcome the Chair's invitation to speak clearly. As somebody who is hard of hearing myself, I would reciprocate and ask that you are clear as well. I look forward to being of assistance to the committee.

The Chair: I think we heard you extremely well. Thank you very much indeed.

Q30 **Baroness Berger:** If I can please start with Dr Price, thank you very

much for the statement you have just shared with us and for setting out the extensive ways in which you have consulted with your members.

In your submission to the committee in the Commons, you raised a number of key points around safeguarding, specifically in areas including the assessment of capacity; detecting both internal and external forms of coercion; the implications for people with mental disorders, intellectual disabilities and neurodevelopmental conditions; and the impacts on suicide prevention efforts, palliative care and the NHS more broadly.

That specific evidence was submitted before the Bill was amended to add the new system of voluntary assisted dying panels. Reflecting on the evidence that you have shared with us in advance of this session, I wonder if you can share, in outline, whether you believe that the creation and addition of a psychiatrist at this different stage has helped to address your concerns.

Dr Annabel Price: Our view is that it does not fully address the concerns that we raised. My understanding is that the role of the psychiatrist on the panel would be to check and scrutinise the decisions that have been made at earlier points in the process. One of the concerns that we have raised is that the panel does not have a clear scope to be able to identify and address unmet need. There are also aspects of the psychiatrist role in the panel that are not commensurate with the roles and responsibilities of a psychiatrist.

We have made three recommendations to the committee regarding the panel function, which address some of the concerns that you have raised. One is to clarify whether it is within the panel's scope to identify and make available assessments and treatments for unmet mental health need. I think that would relate to the question around capacity because we know that people with terminal illness are at high risk of depression.

We ask that the medical membership on the panel should include medical expertise that reflects the needs of the patient. That is broader than psychiatry. When a psychiatrist is present, they should not be the only medical professional on the panel.

Thirdly, we ask that clearer powers are given to call for evidence in more complex cases. That would allow for a more in-depth assessment of some of the areas that you highlight that may well be impacting on somebody's decision to end their life by assisted dying.

Baroness Berger: Can you just expand, please, on that last point, specifically about what areas you think should be included?

Dr Annabel Price: We advocate for a multidisciplinary assessment of need. We know from international evidence that for people with terminal illness depression is common, but also other areas of unmet need may lead to a wish to hasten death. Those would include difficult physical symptoms, feeling a burden and social isolation. These are all things that are relatively common in people nearing the end of life.

There is not a clear mechanism to assess for those areas—those are not exhaustive; there are a number of other things that may be relevant—and to be able to provide the means to address those. At the moment, we feel that those areas are somewhat bypassed in the process, so we would like the panel to have clear powers to be able to assess for those areas themselves and to be able to recommend addressing unmet need.

You also asked about coercion. We have not said anything specific about coercion in our written evidence because we do not think that it is a specific psychiatric area of expertise. It is everybody's business. It is an area that is difficult to rule out confidently, but it needs to be thought about throughout the process, not just for scrutiny at the end in the panel.

Baroness Berger: I have a slightly different question, if I can, please, for Dr Geoghegan. As you have set out in the evidence that you have submitted, social workers who sit on the panels will need to be able to access local authority records and very occasionally police records as a means of detecting when a person has been subjected to domestic abuse, including coercive control. Unfortunately, we know that many of these cases do slip through the net and go undetected either by police or other responsible agencies.

If this power, as you are requesting, were to be granted, it would mean that social workers would have access to this information only after two medical professionals had already deemed the person not to have been coerced or pressured. Do you believe that this power that you are requesting at that stage is enough to make the Bill safe or would it be a case of too little, too late?

Dr Luke Geoghegan: Essential but not enough. BASW takes the view that all applicants should have a safeguarding assessment. It is implicit, but let us make it explicit, that assisted death is irreversible and it cannot be modified or reviewed after it has happened. Death can also trigger a substantial transfer of assets. Even if a person who has an assisted death is cash-poor, they may well be asset-rich and own a house.

At the moment, under the 2014 Care Act adult safeguarding sits under local authorities and it effectively tests a hypothesis. An allegation is made or a concern is raised and that concern is investigated, and then that allegation or concern is either upheld or it is not. The challenge for the panel is that here this model is flipped. Can we be sure that this person is not affected by safeguarding or coercion issues? It is often impossible to prove a negative, but we can make reasonable assessments on the balance of probabilities.

A very common safeguarding failure is the failure to share information between agencies. Social workers on the panel must have the power to routinely access local authority records to see whether there have been safeguarding concerns and, in certain cases, with the approval of the chair of the panel, access police records to see whether there have been any issues of domestic violence or coercive control.

As a very important practical point, if there are safeguarding issues that need to be investigated and there are no concerns raised, that at the moment can be closed only by the local authority. That can take time. Given that local authorities have a backlog of adult care assessments of around 375,000 cases, DoLS assessments and other statutory work, the risk is that, with the timescale of the assisted dying Bill, this would be a slow and tortuous process. The panel in the Bill needs an amendment to close their own safeguarding assessments.

The Chair: Dr Geoghegan, a lot of questions will cover this ground in various ways. We are under some time pressure. Could I stop you there and move on to another question?

Dr Luke Geoghegan: Just to note, Chair, coercive control is not just about forcing people into assisted death. It is about preventing them from assisted death.

Q31 **Lord Markham:** Thank you, both of you, for being here. First moving to the Royal College of Psychiatrists, my understanding is that the survey of your members was roughly 50:50 in favour and against. Is that correct?

Dr Annabel Price: That is correct.

Lord Markham: My understanding is that you are personally opposed to the Bill.

Dr Annabel Price: I represent the college and the college has raised concerns about the Bill. I myself have not stated a position in favour or against the Bill.

Lord Markham: Are you personally in favour or against the Bill?

Noble Lords: Oh!

Lord Markham: Sorry, sorry—I have had a number of statements from psychiatrists. It was a factual question.

Baroness Berger: Then we should ask every panellist.

Lord Markham: That is fine.

Baroness Berger: We did not ask them yesterday.

The Chair: Please, please, please. I think Lord Markham is entitled to put his question.

Lord Markham: What I am going towards here is that the college membership is split 50:50 in terms of those who are in favour and those who are against. I have been approached by a number of members of the college who feel that their views are not represented in here. I can give one example on this, in that I know there are a number of psychiatrists who feel that the Mental Capacity Act is a perfectly adequate way of assessing mental capacity in their professional opinion. Do you accept that there is a body of your members who feel that the Mental Capacity

Act is suitable?

Dr Annabel Price: The way that we have come to our position—

Lord Markham: Sorry, we are tight on time. My question was this. Do you accept that, in the professional opinion of a large number of your members, the Mental Capacity Act is suitable?

Dr Annabel Price: We have thought very carefully through our position and our views, and we ask for a review of the Mental Capacity Act's suitability. To set it out, the Bill currently states that a person is eligible if they have the capacity to make a decision to end their own life. This is not a framework that has been tested for this particular decision. There are principles within the Mental Capacity Act that we are not certain are compatible with this decision and need to be thought through more carefully. For example, should there be a presumption of capacity for this decision? The Mental Capacity Act also makes provision for decisions in someone's best interests.

Lord Markham: Sorry, if I may, I know all members want to come in and there are lots of questions. My question was whether some of your members have the professional capacity, in their opinion, to say that the Mental Capacity Act is suitable. A simple yes or no answer is fine. Thank you.

Dr Annabel Price: There may be members who have that view. I am here representing the whole college. This view has been come to through a process of working carefully with the working group.

Lord Markham: The point is that we need a number of psychiatrists. I believe the impact assessment says you need six psychiatrists who can act on the panel in this case and believe that the Mental Capacity Act is a suitable mechanism with which to do it. Chris Whitty, our Chief Medical Officer, was very concerned that, if you set up a new mental capacity assessment that was separate from the Mental Capacity Act, that would add to confusion. That would not be a good thing to happen. What I am keen on is making a system that works. My understanding is that there are a number of psychiatrists who believe that this system can work and the panel will work adequately.

I believe that the fact that half of your members, roughly a 50:50 split, believe it can work and half do not is relevant.

Dr Annabel Price: The 50:50 split is on the principle of legalising assisted dying. That is not the same as the practice.

Lord Markham: Thank you.

The Chair: Lord Markham, can I interrupt you? Obviously, time is limited. Do you have a question for Dr Geoghegan?

Lord Markham: Yes, sorry. My understanding is that your association welcomes its involvement in the panels. Is that correct?

Dr Luke Geoghegan: Yes.

Lord Markham: In terms of the safeguards, I believe at the moment there are not many safeguards in place. My understanding in terms of how this panel is set up is that the panel actually have the power to ask for any information they deem is necessary for them to be able to make the assessment. Is that your understanding?

Dr Luke Geoghegan: Yes, I do not have the wording in front of me. I think it could be stronger.

Lord Markham: We would all agree as a group that the panel should be allowed to get the information that they feel they need to in terms of professional opinion, so I think you will be singing to the choir there, so to speak.

There is one other thing I just wanted to understand. Obviously, generally the GPs are the front door in terms of any assessment. They assess their patients and, only in the case where they are worried that there is pressure, coercion or any mental health or anything, they will then signpost or refer people to that service. That is the principle that our health system works on in that they are the front line in this service. Is that something that you agree is sensible in this case?

Dr Luke Geoghegan: Yes, it would be the panel's job to determine that there were not any safeguarding concerns, informed by the social worker, and to take the view that there were not any mental capacity issues, informed by the social workers. Most best interest assessors are social workers.

Lord Markham: They are perfectly well able to do that.

Dr Luke Geoghegan: Yes.

Lord Markham: Okay, thank you. I think that all sounds very sensible.

Q32 **The Lord Bishop of Newcastle:** Good morning and thank you for your presence here with us. I have a couple of questions for Dr Price, if I may, and one for Dr Geoghegan. Dr Price, do you think it is straightforward to characterise the Bill as primarily about autonomy? What might the implications for the Bill be, if autonomy is understood as inter-relational? No man is an island, as it were.

Dr Annabel Price: The Bill, as it is set out, is primarily focused on autonomy. There are other models of assisted dying in other jurisdictions that are based around suffering. Autonomy is a thread that runs through this.

Autonomy is a concept that can be interpreted in different ways. There is the very pure personal autonomy where somebody makes a decision uninfluenced by anybody else, but that does not reflect the way that people usually make decisions. People usually make decisions as part of their relationships with others, as you say, and that is very normal. Part

of an assessment of anybody's need or anybody's decision-making would take into account the people who are important to them and the way that they have lived their lives. That would be very normal in a psychiatric assessment, for example.

The Lord Bishop of Newcastle: To Dr Price again, if the Bill were to proceed as drafted, what consequences do you think this might have for any recognition that a person with suicidal feelings can be assessed and often treated and, therefore, what consequences might this have for wider suicide prevention efforts?

Dr Annabel Price: This is something that we have thought about in depth. As you know, the Royal College of Psychiatrists has been campaigning for ways to care for people with suicidal thoughts to reduce suicide. The Mental Health Bill is obviously going through the later stages in the parliamentary process, and a focus in that is on thinking about caring for people with mental disorder.

One thing that we recommend when we ask for a review of the Mental Capacity Act's suitability as a decision-making tool is also to think about the potential consequences for its intersection with the Mental Health Act. One of the duties of a psychiatrist is to think about suicide prevention. The Mental Health Act may well be relevant in that. It is an important area for the committee to consider and for parliamentarians to consider as the Bill processes through the process.

The Lord Bishop of Newcastle: Briefly, to Dr Geoghegan, thank you for being here and for the work that social workers do. I recognise that in many ways you are on the ground in the granularity of life. Are there any populations about which you have particular concern in terms of this Bill?

Dr Luke Geoghegan: Yes. We have been clear from the outset that social care in this country is in crisis and people are not getting the services that they are entitled to. If you are not getting the care services and support services that you are entitled to, an assisted death may be something that you would not have considered otherwise.

We are not experts in palliative care or end-of-life care, but the same argument applies. Unless those services are adequately resourced, that may bend people's decision a certain way. Of course, much of social care is self-funded now. If you are poor and you cannot have access to those personal resources, even more pressure is applied to you.

Q33 **Baroness Hayter of Kentish Town:** It was suggested when Dr Price was asked her personal position that we should ask everyone, so I think we should use the opportunity to ask Dr Geoghegan his personal position on the Bill.

Baroness Berger: We did not do that yesterday.

The Chair: Please do not interrupt.

Baroness Hayter of Kentish Town: I think you should have the

opportunity, particularly in your case because some of your quotes have been used by those who oppose the Bill. I just thought it was right that you should have the opportunity to give your personal position on the Bill.

Dr Luke Geoghegan: I am here because I am a representative of the British Association of Social Workers.

Baroness Hayter of Kentish Town: You do not want to answer the question. That is fine, but that is clear. You have had the opportunity.

I would like to ask a specific question—actually, I think you mentioned international experience earlier—about the role of social workers. In Australia, they have been used quite a lot. I wonder, given that you have some international experience, what you have heard from the Australian experience where social workers have been part of the system.

Dr Luke Geoghegan: We have had contact with colleagues in Australia and particularly in Canada. The challenge of comparing systems across the world is that that cannot be done in isolation. Countries have their own politics; they have their own cultures; they have their own expectations. While that can be a useful exercise, at the end of the day we are making or you are making legislation here in the UK.

Baroness Hayter of Kentish Town: Your answer is no. That is fine. I do not want to take up too much of your time on that.

One of the worries I have with what you said in answer to an earlier question was that by wanting more and more assessment—these are people who are dying; this Bill is about people who are dying—because you are worried about a few people who may have issues of inheritance, you are putting so much in front of people that those who are well supported by their families, who have a clear and settled view, will actually be stopped from what they want to do. Does that worry you?

Dr Luke Geoghegan: There is a real pressure of time because of people's health condition and the framework as envisaged by the Bill. We are arguing for a change in the Bill so that people have the access to resources and support to start thinking about these issues well before the six-month period opens.

In terms of the processes within that six-month period, I come back to the point I made earlier. Assisted death is not reversible, modifiable or reviewable. We need appropriate checks and balances to make sure that this process is robust.

Baroness Hayter of Kentish Town: You accept that they are dying anyway. Could I put a question to Dr Price? I am sorry; I do not know whether it was the paper you put today or the earlier one, but one of your briefings seemed to suggest that alcohol and substance abuse can lead to some of the physical effects and maybe some of those people with those problems may not be eligible. I used to run Alcohol Concern. I have worked a lot with people with alcohol problems. I am hoping you are not

saying—I just want to be clear—that people who have been affected because of that would be excluded, because of their past history, from being able to come through the pathway that is being set out in the Bill. Maybe I just misunderstood your submission.

Dr Annabel Price: Our recommendation is to make explicit provision within the Bill to exclude the direct physical effects of mental disorder. I think we are thinking about conditions such as severe anorexia nervosa, for example, and the very direct effects. What you are talking about is perhaps somebody who has had addiction problems in the past and then is terminally ill at some point distant from that. That is not directly in the scope of our concern. We are thinking about the direct effects of mental disorder on physical health. We know that there is a strong link between the two, certainly in some mental disorders. Anorexia nervosa is one that has been discussed a lot during this process.

Baroness Hayter of Kentish Town: No, it was the alcohol one that I have a particular issue with. We would not want any of our clients from that to be debarred for a completely different illness that they have. That is not a possibility.

Dr Annabel Price: That is not something that we have raised as a key issue, no.

Baroness Hayter of Kentish Town: If I have another moment, I would be interested again—the question that I put to your colleague—about the discussions you have had with psychiatrists in other jurisdictions where they have been working, it looks like, quite successfully. Have you been discussing that with other psychiatrists who do work on this in other jurisdictions?

Dr Annabel Price: We have certainly, as a college, been in contact with colleges and representative organisations from other jurisdictions. I myself have met with and spoken with psychiatrists working in Oregon as part of my PhD and been able to talk in depth particularly about how mental disorder is assessed and how mental capacity is determined.

A challenge that we have is that there is actually very little published about mental capacity determination. That is an area where there is a bit of a gap in certainly the research literature and in the published policy material. It is an area that, I think, needs further consideration.

Baroness Hayter of Kentish Town: You have not actually talked to psychiatrists who are working on it at the moment.

Dr Annabel Price: We certainly have. It has been part of our considerations as we have been going through this process.

Q34 **Baroness Berridge:** Thank you very much for coming this morning. If I could bring you back, Dr Price, to those who take their own lives, are you aware that from the hospice data there is a desire to hasten death often, but, once you provide care and meet those unmet needs, that often abates? You have talked about the international position. Can you

confirm that there is cross-nation data that the total figures of those who take their own lives, especially among women, rise after legislation of this nature is passed?

Dr Annabel Price: There is some research data from the US that shows that the background suicide rate does not reduce with the introduction of legislation for assisted dying. There is an idea that it actually would reduce the suicide rate. We do not see that in research data.

Your first comment was around the association between a wish to hasten death and remediable factors. Certainly, there is research that shows that there is a strong association between a wish to hasten death and depression. Where depression is treated, a wish to hasten death will often reduce. That is, again, data that comes from studies in the US. We also have studies in the UK looking at the association between depression and wish to hasten death in UK hospice populations.

Baroness Berridge: Thank you. It is good to hear from data. Can I just follow that up? I do have a question for you, Dr Geoghegan, as well. In terms of those who take their own lives, if the legislation is passed—I am thinking particularly of young people, and our societal understanding of those who end their lives—we will then have two population groups. There will be those who end their lives outside of the Bill—that is probably the best way to describe it—and those who end their lives under the Bill. Are you concerned about what that will do particularly for young people and the understanding of taking your own life that we currently have in our society and the patient groups you treat?

Dr Annabel Price: Thinking about, societally, what people will think about ending their own lives, essentially, passing a law of this nature will change a society's relationship with what it is to end one's life. I think that is clear. That is in certain situations, but it also means that, as clinicians assessing people who have a wish to end their own lives, we will be coming at it from a different position than we are now.

Whether or not that gives a clearer message to young people about what it is to end one's life, we still, as clinicians, have a duty to suicide prevention and we still have a duty to assessing for mental disorder. That will continue whether there is an assisted dying law or not. An assisted dying law will apply to a small proportion of the population, and we continue to have a duty of care to the whole population, including those under the scope of the Bill.

Baroness Berridge: Just briefly, to Dr Geoghegan, in terms of safeguarding procedures, what is your understanding in safeguarding of the use of the word "pressure" in the Bill?

Dr Luke Geoghegan: I think there are going to be some elements of pressure that we cannot manage. In my response to the Bishop I was saying that we have social care problems. That creates pressure. There is also more personal pressure that may come from family members or partners. That is where the task of safeguarding has to tease that out

and say, "Is this actually the established wish of this person or is this really the established wish of somebody else?"

I would come back to the point that I made before. Coercion is not just, "Why don't you have an assisted death?" Coercion can work the other way. "I don't want you to have an assisted death".

Baroness Berridge: What is your understanding, then, of the difference between "coercion" and "pressure"? They are used in the alternative in the Bill.

Dr Luke Geoghegan: My understanding would be that coercion would be forced.

Q35 **Lord Winston:** First of all, can I say how grateful we are to you for coming today? You have just given us some very important evidence. I have two questions to make about that evidence, if I may. First, Dr Price, I wonder whether I might ask you a very simple question. Many of us who are on this side of the Select Committee are in favour of the Bill and feel very strongly that one of the most important things we can do is to alleviate severe pain and suffering to people in the last few weeks of life. We see that as being something of critical importance. I wondered how you felt psychiatrists deal with that. My impression is that, apart from trying to treat depression, there is very little that you do in that situation for these people. I would be happy to hear what you say.

Dr Annabel Price: I work, in my clinical life, frequently with people who are nearing the end of life, including those who are in the last few weeks and few days of life. I often work as part of a multidisciplinary team. We work holistically. I might be referred a patient who is nearing the end of life where there is a concern about their mood, and what I will identify is that actually they are suffering with great pain, and I will request specific assessments in order to alleviate that pain.

While I myself might not be prescribing the pain medication, I feel that I have enough general expertise to know when somebody's suffering is not because of a primary mental disorder but because of physical suffering.

Lord Winston: Thank you very much indeed. Can I address you by your first name? My first name is Robert and I want to say something very personal to you that I have never said in this place before.

I was brought up, in a deeply religious Orthodox Jewish community, in a Jewish family that would not switch on the light on the Sabbath. My children still do not switch on the light on the Sabbath. We have kept the Sabbath generally. We eat separately as a family in general. I am, I must say, a bit lapsed at the moment. Three or four years ago, when we had a similar Bill in front of Parliament, I spoke against assisted dying for various reasons partly because, of course, the Orthodox view would be that this is too dangerous to go down and against Jewish law. I abstained during the actual vote, and I did so because I felt I could not really impose my view, as a religious person, on the community at large.

I wonder whether you could advise me as a vicar. You mentioned that we are legislating for society, for everybody, not just for certain people. Do you think in a pluralistic society we have the right to impose our particular views on society in general when we are legislating? I think it is a really difficult question.

Dr Luke Geoghegan: No, we do not have the right to impose views. I think the issue is that, if Parliament decides to legislate on assisted dying, it is something that people have to opt into. It is quite a rigorous process and it should be quite a rigorous process because this is about as fundamental as things get, really. Those who have views are not forced into the situation. It is a choice. We exercise choice as a whole level of society. I exercise the choice not to engage with social media because I think it is problematic.

Lord Winston: I agree with you there.

Dr Luke Geoghegan: This is the most fundamental choice—so long as we are not forcing people into it.

Q36 **Baroness Smith of Newnham:** It is slightly difficult addressing the microphone so that my colleagues and the witnesses can hear and looking at the witnesses so it looks as if I am engaging with you, but I will try to do both.

I have questions for both of you, both of them reflecting the capacities in which you have been invited today, do the Royal College of Psychiatrists and the British Association of Social Workers. I am not going to ask about any personal views but very much about the written evidence you have given and the submission that the Royal College of Psychiatrists gave to the House of Commons Public Bill Committee about the Mental Capacity Act.

The British Association of Social Workers talked about the need for the multidisciplinary panel to vote by unanimity. The Royal College of Psychiatrists has talked about the need for having additional medical expertise on the panel. This is a question for both of you. Is a panel of three adequate? Does it need to be larger? The group that is meant to be on the panel but is not represented in the room today is the Bar Council. Have either of you, in your capacities representing the association or the royal college, talked to the Bar Council? Do you believe your associations have talked to the Bar Council about what its views on the panel might be? I will come back to mental capacity in a minute.

Dr Luke Geoghegan: Maybe the last one first: Vicky and I have talked to each other.

Dr Annabel Price: I'm Annabel.

Dr Luke Geoghegan: Yes, we have. I have not talked to anybody at the Bar Council.

Dr Annabel Price: My understanding is that the Royal College of Psychiatrists has not either, although our policy team are behind us and might correct me if I am wrong.

Baroness Smith of Newnham: I am not getting any head shaking or nodding. Thank you. It is just useful to know whether there had been any preliminary discussions. In terms of the submission to the House of Commons Public Bill Committee, the royal college stated the view that the MCA is not sufficient for the purposes of this Bill. I wonder whether you could, on behalf of the royal college, explain a little bit more why that is not appropriate and what rectification there could be, if possible.

Dr Annabel Price: The Bill sets out the decision that the capacity will be assessed for. That is a decision to end one's own life. Now, in clinical practice, that is not a decision that we assess capacity for. The Mental Capacity Act is there for decisions around care, treatment, place of residence. It has a wide application, but it has not been tested for this particular decision. The view of the Royal College of Psychiatrists is that assisted dying is not a treatment. That is something that we have requested clarification on. Is that the view of the Bill Committee? Is that the view of the Bill sponsors? Is this a treatment?

Our view is that it is not a treatment, and therefore it is somewhat different from the usual decisions that a doctor or other capacity assessor would be assessing for. That is why we ask for some clarity around what the starting points actually are for that assessment. Is it right to presume capacity for the decision? That is a duty under the Mental Capacity Act.

My understanding, certainly from research thinking about the Commission on Assisted Dying and debates in the House of Lords, is that there are different views, actually, on whether there should be a presumption of capacity. If there is a view that the Mental Capacity Act is a suitable legal framework, should there be a presumption of capacity? What does that mean? That means that, if somebody does not have a disorder of mind or brain and they are not able to follow the four steps of the capacity assessment, we would need to presume that they had capacity. We will often assess capacity and we must presume capacity. Is that right in this instance?

The Mental Capacity Act is there to protect people who cannot make decisions for themselves and to make decisions in their best interest on their behalf. My understanding is that that is not a provision of the terminally ill adults Bill. That is also outside of the scope.

What we ask is for just some really detailed review and guidance. I may be asked, if this is legal, to give a second opinion on capacity. What do I do in the room in terms of making a determination of capacity with the person sat in front of me?

Baroness Smith of Newnham: May I just ask one very quick question of Dr Geoghegan? The British Association of Social Workers said that the panel should have the right to see the person. Should it be a right or

should it be a duty? Either of those two things could be on the face of the Bill and they would mean slightly different things.

Dr Luke Geoghegan: Yes, if Parliament legislated for a duty, we would not object to that.

I am aware of time, Chair, but I would like to make some comments on the practicalities around mental capacity, if I may, briefly. We think that the issue of mental capacity is going to come up more often than you might expect either from family members or from professionals. The formal level of accreditation for mental capacity assessments is best interests assessors. I think about 90% of BIAs are social workers, although other professionals can qualify as well.

Undertaking a mental capacity assessment is going to be very complicated because of people being in great pain or in a fluctuating condition.

There is also the concept of material time, which is when the decision around mental capacity has to be made. We have debated that within that six-month period, and we have not come to a firm resolution on that.

To link to the point of your colleague right next to you, unless this is properly resourced, there will be delays. Those delay will have an extremely negative impact, in that capacity assessments will not be conducted within the time required.

Q37 **Lord Goddard of Stockport:** I am so pleased that you are here today because yesterday we heard from the Royal College of Physicians, the Royal College of General Practitioners and Royal College of Nursing. The social workers sit even closer to the front line than those bodies because you are dealing with people day to day.

Could I ask you this question? At the moment, over 600 people who are terminally ill take their own lives. I come from a local government background. I share your frustration about the assessments, the backlogs and, at the moment, the lack of safeguards.

If this Bill was enacted, it would put in quality safeguards that are not there now. This is the question I would like to ask you both. Is there something that you could add to this Bill that would make you not exactly support the Bill but accept that it will improve the quality of life for people terminally ill with less than six months to live? I have heard people talk about younger people and other spurious arguments. This is about a specific set of people who have six months or less to live and are terminally ill.

I know the people who will be speaking to those people more than anybody else will be social workers. That is the practicality of the matter. I just wonder whether you think there is a way through this that could actually deliver something. The funding is the issue. It is always the money. We will be hearing from the Treasury in another session. If there

was an unlimited pot, we could probably do something different. Is there a way you could see through this that could actually deliver that better-quality service to people with that condition?

Dr Luke Geoghegan: We have members who are of the view that assisted dying should never happen and is unethical. We have members who are of the view that this is everybody's right and there should not be any restraints. We have about 20,000 members who are saying, "Under what circumstances, where, who, when?" and whatever.

Back to the point I was making earlier, Parliament has decided to bring this Bill forward. Our job is to make it as workable and deliverable as possible, if Parliament chooses to legislate. There are two other things that would further strengthen the Bill. One is support for people before the six-month period to think about whether this is something they want. It is quite implicit in the Bill that people think, "Yes, that is a decision for me", they power on and it all happens. Back to your point about being on the front line, we think there are going to be pauses, reversals, changes of mind, delays and family arguments. People need support through that process.

The other thing that I think would give assurance is that no public sector organisation should mark its own homework. The voluntary assisted dying service needs robust external inspection. All health and care services in the country have that from the CQC. The voluntary assisted dying service should have it too.

Dr Annabel Price: Throughout all of our considerations as a college, we have kept in the centre of our thoughts and our considerations the needs of the person requesting an assisted death and the whole population who might be eligible for that. That is at the centre of what we have been considering.

The 10 recommendations that we have submitted to the committee are all intended, if taken up, to improve the Bill in order to meet the needs of that population, but I would like to draw your attention to two of the recommendations that we have made that are particularly pertinent to your question.

The first is to require that each applicant is holistically assessed at the stage of preliminary discussion. We know that unmet need leads to suffering and suffering leads to a wish to hasten death.

The second is to mandate that appropriate and timely treatment is offered where need is identified. 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.

I would like to reiterate that the college does not take a principled position on whether there should be a change in the law or not. We are trying to make sure that the Bill currently before you is one that meets the needs of people, particularly those with mental health need.

Q38 **The Chair:** Before I open up to the committee for supplementary questions, I want to ask both of you whether you have anything to add to your opening statements. Are there things that you would like to say that have not been said? We will then open up to wider questions. Do you have anything to add?

Dr Annabel Price: We have made a recommendation that professional involvement in the process should be via opt-in. One of the reasons for that is that our view is that there should be very robust training and oversight for anybody who is directly involved in the operation of the Bill. One thing that our working group has raised consistently as a concern is the impact of unconscious bias, which we as psychiatrists are very aware of. We might call it transference or countertransference: the impact of the relationship on the decisions that might be made.

One of our recommendations that I have not raised so far is that doctors who are involved in assessment be trained and have relevant supervision in how unconscious motivations might impact the decisions that are made in the process. That would need to be added to the other training that has been proposed.

Dr Luke Geoghegan: Yes, one point we would like to make is that the decisions of the panel need to be unanimous with no abstentions. The Bill, as it currently stands, is contradictory on this. We think that, if you have a professional opinion that is genuine and evidenced, you should not be outvoted. I think we would feel that; I suspect you would feel that as well. I think it prevents problems later because people then come out of the woodwork and say that somebody did not have mental capacity or there was a coercive issue or whatever. I also think it would boost public confidence because all the professions have peaks and troughs in the public mind, and actually holding us all accountable would strengthen that.

I am fairly old-fashioned on the issue of abstentions. You are paid to do a role and part of that role is to take a decision, not to abstain. If you have problems with voting for, you should vote against, as a professional.

Q39 **Baroness Scotland of Asthal:** Can I thank you both for your evidence? It has been hugely helpful, particularly the fact that you are professionally representing your professions, as opposed to your private, personal views. I very much appreciate that.

I want to ask, if I may, about the issue of holistic assessment at the beginning. Both of you have highlighted that we need a comprehensive assessment of need, so that there can be a better informed decision. Bearing in mind that one of the greatest causes of morbidity in women and girls is domestic violence, can I ask whether it may be possible to adopt the approach of the multiagency risk assessment that we use in those cases for these cases at the beginning?

As soon as someone has this terrible diagnosis that they are terminally ill, there could be, at the beginning, a multiagency risk assessment to ascertain what their needs are and how to then help them through the

remaining time. Do you think that might be helpful?

Dr Annabel Price: May I clarify whether you are asking if that is for any person who is diagnosed with a terminal illness or just applicants for assisted dying?

Baroness Scotland of Asthal: The indication from the evidence you gave was that it might be helpful for everyone so that, before they make that decision, you already know the risks, the pressures that may be on them, the palliative care opportunities and what particular needs they may have as a result of their family and the other information.

I was very much taken with what both of you have said in relation to having all the information, so that you are not making a decision on a siloed basis, which flaws the decision, because you do not understand the whole picture. You would have all the agencies coming together to assist in that multiagency approach. The reason I was talking about the MARAC is that there is an agreement between the agencies about the sort of provisions they have and how they are going to do it.

If you remember, we used to have hours-long case conferences. They went from hours to being able to do a multiagency risk assessment, having predetermined what the rules were, in about 15 minutes. It was fast, effective and helpful. As you were talking, I was thinking that that may be a system that could be adopted. I wanted to know what you thought about it as an improvement, very much conscious that you are trying to think, if this Bill is going to go ahead, how we make it happen, how we make it practical and how we determine who needs what.

Dr Luke Geoghegan: The function and model of the multidisciplinary team needs to be made clearer. There is an implicit model, which is very much in the Department of Health's impact assessment. This is literally a committee, rather like a board of directors, which meets once every six weeks and people give it submissions. I am like, "Where are these submissions coming from?"

We would like to see a model much more around a panel that provides a range of services that are appropriate for that person. Some of that might be around counselling and support. Some of it might be around mental capacity assessment. Some of it might be around meeting mental health needs.

The strength of the multidisciplinary panel model is that professionals can get engaged in groupthink. When I have been in multidisciplinary work, it is really refreshing that another professional says, "Have you thought about", or, "Why don't we", and you think, "Yes. That is so important".

For example, on the issue of mental capacity, I would be hoping and expecting that, in a panel, if there were concerns about mental health, the psychiatrist would be liaising with the social worker to say, "What are the issues around mental capacity?" and the social work doing the mental capacity assessment would be saying, "Are there any mental health

issues that are affecting my assessment?" This would be a truly joined-up—often an overused word—holistic service to support people when they are literally at their most vulnerable.

Q40 **Baroness Finlay of Llandaff:** If I can go for a moment back to the Mental Capacity Act, the fundamental principles in Clause 1 of the Act are that the person, as you have said, must be assumed to have capacity and, secondly, that all practical steps are taken to support them. Only after that, and if you have accepted that their decision may be an unwise decision, is there an in-depth assessment of whether there needs to be a best interest decision taken on behalf of that patient. That assessment is proportionate to the size of the decision to be taken.

There is also, of course, Clause 58 in the Act, which states that the Act takes into account the law relating to murder or manslaughter or the operation of Section 2 of the Suicide Act 1961, Clause 60, assisting suicide. I wonder how you feel that, in practice, the Mental Capacity Act would work in relation to assessments. Do we need to move that assessment upfront, rather than having it after the first three phases?

Should the panel itself be seeing the patients at the outset, to undertake those assessments that you have referred to in depth, rather than seeing the paperwork and hearing from only one doctor, not both, with no recorded transcript or video of the consultation itself to assess the validity of the way that those assessments earlier on have been undertaken?

We use recording in A&E. The police use recording. We use it for teaching. Psychiatry uses it quite a lot. Therefore, does the whole role of the panel need to be completely rethought to give it judicial-type powers as well to ask questions, interview people and go more widely?

Linked to that, for the social worker on the panel, should there be a requirement that the social worker undertakes a home visit? The way a person presents in a clinical setting may be very different from the situation you find when you do a home visit and all that is revealed through that. That is quite a common clinical experience, particularly where there is worry about undue pressure, coercion or behaviours that are going on.

The Chair: Could you keep your answers fairly short? That was a very, very long question. In fairness to the others, I wonder whether you could be very brisk.

Dr Annabel Price: I probably need to perhaps focus in on one or two areas in your question. One is what a mental capacity assessment would look like. How would it be done? The answer is that it is not a capacity assessment that is done in clinical practice at the moment, so we do not know. It is not a capacity assessment that has been tested in court, in terms of its validity.

A capacity assessment would need to take in all of the relevant information to be discussed. We need to go back to whether this is a

treatment. Everything flows from that. There are question marks around how that assessment would be completed and the relevant things to go into it. That does need to be further considered.

The other part of the question is whether the panel should have a greater ability to do that in depth. One of the things that we have said in our longer written briefing is that we advocate for detailed information on every applicant's process to be made available, in order to be able to scrutinise the quality of all of the assessments, including the capacity assessment.

One of the difficulties that we have is that we do not have detailed information about how capacity assessments are done in other legislatures, because the information is not available in detail. That is something that we have advocated for all the way through.

Dr Luke Geoghegan: Every applicant should have a safeguarding assessment. Only a proportion will need a mental capacity assessment, because we are of the view that everybody should be assumed to have capacity, unless there is doubt otherwise. Back to Robert's point, this is about opting in. Yes, a mental capacity assessment should include an interview and a home visit, which is back to the point about duties and powers for the social worker to see people.

Q41 **Baroness Hayter of Kentish Town:** First of all, you probably both accept that, at the moment, there are no safeguards whatsoever. People who go to Switzerland have absolutely no safeguarding about coercion, family inheritance, feeling a burden, whether in fact they are really dying or whether they have the capacity. You would probably both accept that, even if it is not adequate, what is there at the moment must be much better than what there is for people who go to Dignitas.

I have two specific questions. One is about the panel. In answer to my colleagues about whether the panel has a duty to see the person, that seems to me to fly in the face of what Dr Price said about the needs of the person. This would be forcing someone to have to see a panel, at a point when they may not be able to move out of their hospital bed. Therefore, the panel would have to come to them.

If it is a duty, if I have understood it, then the person concerned would have no freedom over that. They would have to see the panel. I would like your comment on that.

If I understood him, Dr Geoghegan said there may even be a veto. I wonder how any social worker—or, indeed, psychiatrist or lawyer—would feel if they had the veto and therefore a single person stopped somebody who wanted to have assisted dying from doing so. We talk about the professionals' involvement. Can you comment on how a social worker could deal with the burden of having a veto and therefore stopping what everyone else had agreed was a good thing?

Dr Luke Geoghegan: The characterisation of an applicant appearing before a panel is not fully accurate. I would hope that something like a

mental capacity assessment would be done sensitively and gently. You would be going into people's homes, with their permission, at a time that suited them. That would be done in a gentle and appropriate way, rather than being an interrogation.

Baroness Hayter of Kentish Town: I meant the whole panel. You may have misunderstood. I thought the suggestion was that the whole panel should see them. I may have misunderstood.

Baroness Smith of Newnham: My question was about right versus duty.

The Chair: Baroness Smith, please, wait a moment. We are going to have to stop at 11.25 am. The questions have been very long and I really want to—

Baroness Smith of Newnham: I apologise, Lord Chairman. I was merely trying to assist and confirm that Baroness Hayter was correct in saying I had suggested the word 'duty'.

Q42 **Lord Winston:** Dr Price, your colleagues at your college do assess for the removal of treatment from people who are being sustained at the present time. The removal of sustaining treatment is part of a psychiatrist's need—yes or no?

Dr Annabel Price: We might support in those decisions.

Q43 **Baroness Berridge:** I think I cut you off. You said that coercion is about force. What would pressure be? Dr Price, what would you understand the word "pressure" to mean in the Bill? First, finish off your answer. I think I cut you off. You said—

Dr Luke Geoghegan: You did not.

Baroness Berridge: I did not. Then what is your understanding, Dr Price, of the word "pressure" in the Bill?

Dr Annabel Price: It is not something that we, as a college, have scrutinised or tried to define for ourselves. My personal understanding of coercion is that it would be—

Baroness Berridge: It was about pressure, sorry.

Dr Annabel Price: It would need to be differentiated from coercion in terms of its definition. Coercion would be the application of force, threat or fear in order to make somebody do something they did not want to do. Pressure has a broader definition of perhaps strong encouragement, expectation or the worry of letting somebody down. Coercion, in my understanding, can potentially be a crime, whereas pressure perhaps does not fulfil those criteria.

We see people in my clinical practice who have been pressured in various ways to do things that they might not have made the decision to do themselves. An example that comes to mind is that we, sadly, see people

who have entered into suicide pacts from time to time. Sometimes, one of the couple may have been pressured by the other member of the couple. There may have also been coercion. Those are examples, but is there a clear distinction? That is for the parliamentarians wording the Bill, perhaps, rather than us.

Q44 **Baroness Hayter of Kentish Town:** I was hoping we would have an answer to my question, please, about the possibility of a veto, but also on the position at the moment. I would like you both to comment. Do you agree that, at the moment, there are no safeguards whatsoever when people go to Switzerland? Surely you would both accept that, even if we make no changes to the Bill at the moment, it is a vast improvement on what we have at the moment for those who do take their own lives early.

Dr Luke Geoghegan: The safeguarding aspects need to be strengthened, hence our—

Baroness Hayter of Kentish Town: You are not answering my question, whether deliberately or not. If the Bill went through as it is, unamended, if that was the will of this House and the will of the House of Commons, would you accept that the addition of the safeguards in the Bill, even if you think they are not sufficient, are a great improvement to the status quo?

At the moment, someone can go to Switzerland or, indeed, commit suicide themselves here, but there are no safeguards whatsoever. Even the Bill as it stands must be an improvement, compared to those who go to Dignitas and take their own lives there.

Dr Luke Geoghegan: If the Bill went through as it is now, there would be significant problems because it does not interface with Section 42 of the 2014 Care Act on adult safeguarding. There would be all sorts of practical and legal problems arising from that.

Baroness Hayter of Kentish Town: I am sorry. This is really important. You are saying, even with adding some safeguards, it is no improvement on the current situation, where there are no safeguards whatsoever, when people go to Switzerland.

Dr Luke Geoghegan: I cannot make broad value judgments. What I can do is offer specific areas where the Bill can be improved.

Baroness Hayter of Kentish Town: I understand that. Dr Price might want to comment. Even if the Bill is flawed, with all the problems and the fact we have not defined "pressure", would it be an improvement on what we have at the moment? Someone can go to Dignitas without anyone even checking they are actually dying.

Dr Annabel Price: We have, individually and as a college, been asked this question before. My response would be that it looks for a certain equivalence or an either/or. We have taken a position of trying to improve this Bill, using our expertise to do that. From time to time, we meet people who intend to go to Dignitas. Those people are often

suffering greatly. We will continue to meet people who are suffering greatly, whether this Bill passes in its current form or not.

The idea of an equivalence between those two things in order to perhaps negate really doing the work on making sure that this is as safe as possible, meets mental health need and meets the needs of people potentially does a disservice to the work that is going on right now to try to make this Bill as good as it can be.

The Chair: I am going to have to bring this session to an end, because we have another session to follow. I want to thank you both very much indeed for the evidence you have given. It is extremely helpful to us. The clarity with which you have answered the questions has been absolutely first class.

Can I remind you that the evidence you have given is on a transcript, which will be circulated to you? We would be very grateful if you could check it and be sure to remind us if there are any inaccuracies we should be aware of. Thank you both very much and I end this session at this point.