



Terminally Ill Adults (End of Life) Bill Committee

Corrected oral evidence

Thursday 23 October 2025

11.35 am

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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. 4

Heard in Public

Questions 45 - 58

Witnesses

I: Dr Suzy Lishman CBE, Senior Advisor on Medical Examiners, Royal College of Pathologists; HH Thomas Teague KC, former Chief Coroner of England and Wales; Professor Aidan Fowler, National Director of Patient Safety, NHS England.

Examination of witnesses

Dr Suzy Lishman, Thomas Teague and Professor Aidan Fowler.

Q45 **The Chair:** Welcome to this, the fourth session of our inquiry into the Terminally Ill Adults (End of Life) Bill. We are joined at this session by Dr Suzy Lishman, Professor Aidan Fowler and His Honour Judge Thomas Teague KC. We would be grateful if you could introduce yourselves briefly the first time you speak.

Today's meeting is being broadcast and a verbatim transcript will be taken for subsequent publication, which will be sent to you to check for accuracy. I refer to the list of Members' interests as published on the committee's website. I would invite you to introduce yourselves and, if you would like to make a brief statement in supplement, please do. I think it is sensible to ask Dr Suzy Lishman to speak first and then I will move to the others.

Dr Suzy Lishman: Thank you for giving me the opportunity to speak to you all on behalf of the Royal College of Pathologists. I am a consultant histopathologist and medical examiner in Peterborough. I am past president of the Royal College of Pathologists and I am currently its senior adviser on medical examiners.

I would like to give a very short introductory statement, if I may. The Royal College of Pathologists has no position on the ethical issues related to assisted dying. It does, however, have a view on Clause 38 in the current version of the Bill. This states that assisted deaths will not require notification to the coroner purely because death was assisted. By default, this means that all assisted deaths would be scrutinised by a medical examiner, as all non-coronial deaths in England and Wales must be, in keeping with the regulations enacted in 2024.

The view of the Royal College of Pathologists, the lead college for medical examiners and responsible for their training, is that assisted deaths should be notified to the coroner, just as other deaths following the administration of drugs, prescribed or not, must be. The college's concern relates only to the involvement of medical examiners after an assisted death has taken place. As part of their scrutiny, medical examiners would need to review the process leading to an assisted death, which they are not qualified to do.

The medical examiner system was implemented to scrutinise patient care, not to identify discrepancies or malintent in the legal process required for assisted deaths. Notification to the coroner following an assisted death would ensure independent judicial review, which is particularly important given the concerns raised by some about the lack of adequate safeguards in the Bill for vulnerable people.

It would also be in line with current regulations, with all deaths due to medical intervention or a medicinal product being notified to the coroner. Lawyers, not doctors, are the most appropriate professionals to review assisted deaths.

Professor Aidan Fowler: Good morning. I am the national director for patient safety in NHS England. I am also deputy medical director there and a deputy chief medical officer at the Department of Health and Social Care. I am here representing NHS England, not as an individual clinician commenting.

I am here because, while, normally, the national medical examiner would have attended, the last national medical examiner retired last month and the new appointment, which is a Secretary of State appointment, is being made currently. We expect the new national medical examiner to start next month, so there is an interregnum. The national medical examiner is an employee of NHS England and reports to me.

NHS England has been clear, since the introduction of the Bill, that it is neutral on the principle of whether assisted dying should be legalised. This is in line with the DHSC and Government position that this is a matter of conscience for Parliament to decide. In providing support on the workability of the Bill, NHS England has made no assumptions about how an assisted dying service would be implemented, including whether the NHS has any role in commissioning or providing an assisted dying service.

Should Parliament decide to pass this Bill, NHS England will work with the Government to support implementation of the service as required. If Parliament decides that assisted deaths should be certified in the same way as natural deaths, NHS England and Government will work with the medical examiner profession to enable adequate numbers of the workforce to be appropriately trained to support this new legislation and its potential operational impacts.

The operational model for how an assisted death would be scrutinised by a medical examiner, or what they would or would not be responsible for, has not yet been determined. This would be developed if the Bill receives Royal Assent. We recognise the concerns of the medical examiner community and it would be important to work with them, along with any training and guidance, to be clear about the process and accept their right to not take part if they so choose, and to ensure that those who do choose to be a part of that scrutiny are appropriately trained and equipped.

Thomas Teague: I am a recently retired circuit judge and I served as Chief Coroner of England and Wales from my appointment at the end of 2020 until my retirement in May of last year. I should make it clear that I am not authorised to speak on behalf of the current Chief Coroner or the coroner service generally, and any views that I express are my own.

My involvement with the Bill has been that I have criticised what is now Clause 38. In particular, I developed my views and set them out in an article published in *New Law Journal* in May this year and I have summarised them for the purposes of the committee in a short statement, which I hope you have all seen.

We have in this country, after more than two centuries of debate, just about put the final touches to a comprehensive, principled system of death investigation. For 200 years, a debate took place as to whether the proper professionals to investigate deaths were medical professionals or legal professionals. That has now been resolved only in this century and the position at which we have arrived is that natural deaths will be scrutinised by medical examiners—who are, of course, highly trained doctors—and unnatural deaths, as formerly, will be investigated by coroners. As a result of the recommendation of Tom Luce in his fundamental review, published in 2003, all coroners must now be legally qualified.

Since assisted deaths are by definition intentionally self-inflicted, they are, in my view, both in law and in reality, deaths by suicide and therefore unnatural. Our law has mandated for centuries that all such deaths should automatically go to the coroner for investigation.

My concern is that the proposed removal of what are called assisted deaths from the category of unnatural deaths would do nothing to address the real risks that are liable to accompany those deaths, risks which the Bill recognises in its long title by accepting that there have to be safeguards. Indeed, the risk, in my view, is that re-categorising assisted deaths—which are, in reality, deaths by suicide—as natural deaths may have the unfortunate and unintended consequence of tending to obscure and conceal those risks, making it easier for persons who want, for example, to exercise coercion, pressure or deception, to do so.

The position I take is that the coroner's duty to investigate all violent and unnatural deaths should be retained in its present form, a form that is known to be compliant with Article 2 of the European Convention on Human Rights. We should not take away the jurisdiction of the coroner to investigate those deaths. Were we to do so, we would be creating, I think for the first time, a new category of intentionally procured deaths that would not be subject to automatic judicial scrutiny.

Q46 Lord Winston: I wonder why that new category you are suggesting would make a difference and why you think that is so important to raise at this moment.

Thomas Teague: It would make a difference because, as I understand it, the proposal is that, instead of being investigated by a coroner, it would be scrutinised by a medical professional, a medical examiner, and therefore would not receive the in-depth forensic scrutiny that a coroner currently gives all unnatural and violent deaths.

Lord Winston: When I gave up clinical medicine a long time ago, I took a job in pathology and I ended up doing a certain number of post-mortems, always under supervision with a senior pathologist helping me to make a proper diagnosis. He was a very good pathologist. One thing that he taught me was that the post-mortem never gives you an absolute answer. That applies whether you do histopathology or anything else. There are always elements of doubt there. That is one of the issues,

perhaps, that we should be looking at.

What I want to do is very simple. There have been a lot of issues about assisted dying, the ways that we do it and the drugs that are used. I have been reading the pathology literature, which is pretty lurid. It seems to me that most of the people who have been given drugs and have been then examined pathologically at post-mortem have shown horrific effects. For example, in Ohio and Florida, post-mortems done on victims who are about to be executed, perhaps after years in prison, show, for example, massive oedema in the lungs. Of course, they have been trying to breathe and they cannot, because of the drugs they have been given.

These things are tending to be presented as reasons why we should not be doing this. Do you think there is any way we can ensure that we have safety of the drugs we do use, which would not require the need to make certain through pathological investigation? That might be something like a post-mortem, which would often be required by the coroner.

Dr Suzy Lishman: I will answer that in two parts. First, there is often a misunderstanding about the role of the coroner in the investigation of deaths. Many people believe that it involves a post-mortem, a long, drawn-out inquiry, an inquest with a jury and witnesses, and that it can be distressing and cause delays for families. That is possibly one of the reasons behind the proposal that assisted deaths should not go to the coroner.

It is not, in reality, the case. Around a third of all deaths are already referred to the coroner. 175,000 deaths in 2024 were notified to the coroner, but only a relatively small proportion of those—under 50%—had a post-mortem. It is entirely possible for deaths to be investigated by the coroner without a post-mortem examination. The coroner does much more than just look at the medical cause of death. They review the entire process, including the legal aspects that would come up in assisted dying.

My role here is representing medical examiners. Unlike all the other witnesses you have heard, we come to this after the death. Our views on assisted dying are really irrelevant. We are looking at the safeguards you can put in place after death to ensure that the legal process was followed appropriately and that there are no concerns that need to be raised. When it comes to the safety of the drugs, there are mechanisms already in place to assess drug safety.

I know there have been calls for more clarification about the drugs to be used for assisted dying, and for them to be tested and licensed appropriately, as all other drugs are, but that is not my area of expertise.

Lord Winston: We are short of time, but you may have something you quickly want to add.

Professor Aidan Fowler: I do not have the expertise to add to any concerns about the medications used. I know that there has been a concern from some of our medical examiner colleagues about what to do

if death, for example, were prolonged after administration of medications and so on.

Q47 **Baroness Scotland of Asthal:** If I can understand the position that you are in, Professor Fowler, basically you are saying that whatever the House decides you will implement. You are reliant, in effect, on the expertise of both the examiners and the coroner as to how we should do this.

Professor Aidan Fowler: Yes.

Baroness Scotland of Asthal: I can then concentrate my questions, if I may, on the other two, because you will be relying on them, as are we. I will come to His Honour Judge Teague first because, in your very helpful statement, you said you cannot envisage any alternative means of investigating such deaths that would provide an adequate substitute for the coroner's present jurisdiction, nor did you think it would be sensible to confine the coroner to investigating selected cases.

Could you just amplify for us why? What sort of things come out of this service now that we would need to know if this service is made available, if this law is passed? Why do we still need the coroner in order to make sure that the safeguards we are putting in actually work?

Thomas Teague: In a nutshell, my point is that this is a retrograde step. That is why I gave the brief historical introduction. There was a reason why it was felt that unnatural deaths should be scrutinised by coroners: because they are best equipped to pursue wider and deeper inquiries than purely medical ones. They can investigate the background of a case, can seek evidence from different sources, other than medical sources, and so on.

Therefore, any alternative system that you devised, if it were to be an adequate substitute for the present coroner system for investigating assisted deaths—which are, I repeat, whatever you may label them, unnatural deaths—would end up looking so much like the coroner service that it would have to incorporate the same elements. You might as well stay with what you have. That is really what I am saying.

The second point is that it is not sensible to confine the coroner to investigating selected cases that have been filtered through a triage process less rigorous than the coroner's own scrutiny. When I say "less rigorous", I am not insulting medical examiners at all. They have different training, different skills and a different scope for the scrutiny they apply. This is why, in my statement, I emphasised the inquisitorial nature of the coroner's jurisdiction. It is pretty much unique in English law.

In other courts, people bring cases to the court. They are parties to those cases. They, in effect, own the case and the judge, the jury, whatever, the tribunal, is a referee given the task of resolving a dispute between participants, between parties. There are no parties to an inquest. An inquest is an investigation and it is for the coroner to pursue the

investigation. If a case should be referred to the coroner, it should be left to the coroner to investigate it.

The problem with the proposal in the Bill is this: as I understand it, medical examiners are going to be expected to operate as a kind of filter system to detect cases that ought to be reported to the coroner. Currently, any death by suicide would automatically be reported to the coroner and the coroner would undertake the task of sifting cases, although they all have to go to inquest in those particular examples.

If you set up a filter system that does not have the resources, skills or training of the coroner to intervene before the case reaches the coroner, there is an obvious risk that cases that ought to go to the coroner will slip through, through no fault of the medical examiners, because they are applying a less rigorous and much narrower form of scrutiny. That is the point I am trying to make and that is why it is so important that these matters should stay with coroners. Indeed, it is why it is dangerous to take any element of control over the investigation away from coroners.

Baroness Scotland of Asthal: At the moment, what I am hearing from the medical examiners is that the relationship between the coroner and the medical examiner works efficiently and effectively. The combined skills mean that we can analyse the deaths and understand whether, in fact, the diagnosis that was given actually was merited. We are also able to identify cases where, perhaps, there is malpractice, where people have not behaved properly. It is built on that unity of purpose that the service has been developed. Have I understood both of you properly?

Thomas Teague: Yes, accepting, as Dr Lishman has said, that there is a clear demarcation between the roles of the two, and the scope and nature of the inquiries that they make. It must be remembered, I respectfully suggest, that, as the Bill itself acknowledges, what it calls "assisted deaths" are intrinsically more likely to involve risks of things going wrong than, for example, deaths of unknown cause, which also go to the coroner.

Baroness Scotland of Asthal: If we remove the coroner and remove the system we have now, do you think we will be as easily able to identify abuse or when people may have behaved improperly?

Thomas Teague: Certainly not.

Dr Suzy Lishman: May I add to that, please? Medical examiners are a relatively new medical speciality. We became statutory on 9 September 2024. We have only been in place for just over a year. Medical examiners were recommended in the second report of the Shipman inquiry in 2003 and put into legislation in the Coroners and Justice Act 2009. It has taken 15 years to get where we are.

Because of that, we have worked very closely with the coronial system and the existing systems that are present. Medical examiners are not trained as coroners. We are not trained to review the legal aspects of

death and we are not trained to review unnatural deaths. As soon as there is any hint or suspicion that there may be an unnatural element to a death, that case would automatically go to the coroner. It is not something that medical examiners have training or experience of.

The other point I would like to make is that, while it may seem like semantics, medical examiners do not investigate. We review the case. We review the medical care. We will look at, for example, whether the diagnosis was reliable and whether the treatment was appropriate. Were there any delays in care? We are not looking at the legal framework in which that death takes place.

We do not have the right to ask for evidence or ask people to give us things. We can legally access health records that are relevant to the cause of death, but that is it. We do not have the same powers that the coroner has to request additional information.

Baroness Scotland of Asthal: If we were to have—and God forbid this should happen—a Shipman again, how would you deal with it under the new system?

Dr Suzy Lishman: It is an interesting point. Some people comment that Shipman would have made a very good medical examiner. He was bright and he would have been able to use the system. Now one could argue he would be on the assisted dying panel.

However, as medical examiners, we are not there looking for the criminal aspect of what Shipman was doing. We would have identified him because we would have looked at the case records of the people who had died. We would have looked at the progress of their disease and the diagnoses that they had, and then we would compare that to the death and the circumstances of death that we were given. We would recognise that, where somebody was previously up and out and shopping, and the next day had a home visit from a doctor and was dead, that did not tie up. That would immediately trigger, "We've got concerns here. We will send it to the coroner", and then our involvement would end completely.

The second way in which somebody like Shipman would have been identified is that medical examiners, because we identify all deaths that do not go to the coroner, are able to spot trends, and so we would notice that an individual doctor had two, three or more of these deaths. That would ring alarm bells as well, even if the first one had managed to slip through the net.

Baroness Scotland of Asthal: In your view, would it be safe to remove the coroner's oversight? If we are going to have this new assisted dying, would it be safe to remove the oversight of the coroner in these circumstances?

Dr Suzy Lishman: No, I do not believe it would be safe.

Q48 **Lord Patel:** Thank you all for coming today to help us with this evidence. It is difficult not to look at you as president of the Royal College of

Pathologists, because that is how I knew you. Dr Lishman, this is a question for you as a medical examiner. What other duties as a medical examiner do you have, apart from looking at cases and the circumstances around their death, as far as the bereaved families are concerned?

Dr Suzy Lishman: I have put in my written statement that medical examiners have three roles. We make sure the cause of death is correct. We know doctors are not always that good at formulating the cause of death appropriately, so we have a lot of training on that.

The second thing we do is to determine whether a case needs to go to the coroner, because, as soon as there is any suspicion, it must go, and our involvement ends.

The third is involvement of the family and detecting whether they have any concerns. Medical examiners have a statutory duty to speak to the bereaved family or the named next of kin of people who have died. We explain to them what is on the death certificate. Often, it will use medical terminology that families are not familiar with, and so we will explain what it means. We will also relate what that says to what they may have seen, and answer any questions they may have about the official cause of death. We ask whether they have any questions at all. Finally, we ask whether they have any concerns. People often say, "Oh, no, the treatment was wonderful. Everybody was brilliant".

I always end my conversation by saying, "Is there anything we could have done better?" It may sound like we are going looking for trouble, but that is when you get the really good soft intelligence that can help to improve care for future patients. Although we are trying to support the bereaved family—and bereaved families are at the heart of the medical examiner system, as they are for the coronial system—we are also trying to learn to prevent and to improve care for future patients.

Lord Patel: In the event that all assisted deaths have to go to the coroner, what would be your relationship then with the families?

Dr Suzy Lishman: We, as medical examiners, would have no involvement if deaths were referred directly to the coroner, as happens now. If somebody dies in a road traffic collision, for example, the police would inform the coroner. As a medical examiner, I would never know anything about it. The coroner, however, does work with coroner's officers, who are highly trained to have those sensitive conversations with families, and so they would be having those. We have learned a lot, as medical examiners and officers, from coroner's officers, about how to approach bereaved families.

Lord Patel: Thank you very much indeed. If I can ask now, Sir Thomas, about the role of coroners, if all assisted deaths are to be referred to the coroner because they are natural deaths by definition, as you said, what would be the role then of the voluntary traditional commissioner and the panel?

Thomas Teague: The role of the panel—and you are talking about the assisted dying commissioner, right?

Lord Patel: Yes.

Thomas Teague: I am bound to say that I am reluctant to comment on other aspects of the Bill, but it does seem like a factual question. The panel would look, as I understand it—this is the Bill's intention—at eligibility, and would make the necessary inquiries, so the Bill provides, for eligibility to be determined.

One important concern is what happens after that. What happens after eligibility has been decided in favour of assisted dying if the person who has applied changes her mind, if the person who has applied wants to change her mind but is dissuaded from doing so, or if the person who has applied loses her capacity? What is to happen then?

At the moment, as I see it, there is a complete cut-off once the eligibility panel has done its role, and that is one of my concerns. That is why a proper, thorough, forensic, posthumous investigation is necessary because that will cover the entire remainder of the process, which is important, right through to and including the death.

That is very important because, as I point out in my statement, it is the very certainty that all unnatural deaths will be examined by a coroner that generates the disincentive to people to misbehave, and that creates, if you like, a deterrent against wrongdoing. It has to be known by all concerned that there are no exceptions. If an unnatural death occurs, or a violent death occurs, it will be examined forensically by a coroner. Anything less than that makes it easier for wrongdoers. That is the point.

Lord Patel: If I can go back to the question I asked Dr Lishman about what the relationship of the medical examiner is with the families, in her reply she did state that, in the case of assisted death, the medical examiner will have no involvement if all the cases were to go to the coroner. Would the relationship of the coroner to the bereaved family in the event of assisted death be different?

Thomas Teague: Not essentially. As Dr Lishman correctly said, coroners' officers are highly trained in dealing with families. Pretty much the first thing they do is contact the family. They are very experienced at it and they work with the family throughout, so they would have a very, very close relationship, not just through the court proceedings but behind the scenes with the family, so it would be a very thorough process indeed.

Lord Patel: Thank you very much. Dr Fowler, you are in a difficult position because you really are the NHS England lead that advises the medical examiners. In the event, as you already said, your guidance will have to change, but the medical examiners, if all cases were to go to the coroner, will have no involvement.

Professor Aidan Fowler: That is right, yes.

Lord Patel: In that case, there will be no different guidance from what it is now.

Professor Aidan Fowler: No.

Lord Patel: If I change tack, in your role as director for patient safety, do you see any aspects of what we talk about today in any way affecting patient safety issues?

Professor Aidan Fowler: I think we are talking about the protections for any malfeasance, if that is the right term, during the process of assisted dying, and the debate is about how best to protect that. That is an important debate, and it is one that medical examiners, I know, have concerns about. There is nobody better than Dr Lishman to share that information. I do not hear from medical examiners any different position from what we have heard, but I think, then, if the decision is that the initial scrutiny is by medical examiners, our role is to support them and train them in a way that they feel comfortable. They are used to looking at medical processes. This is more of a legal process. They would need to be trained in a way that we are confident that they could spot any concerns and, at that point, they would then escalate to the coroner anyway.

Q49 **Lord Goodman of Wycombe:** I have a question for Dr Lishman arising out of something you said, which was that medical examiners are not investigators, so let us just hold that thought for a moment. Could they be trained to be investigators? Is there any provision for that in the Bill? Above all, given the story you told of how they have come into being and how long it has taken, would they want to be investigators, in your view?

Dr Suzy Lishman: That is a very good question. Medical examiners are senior doctors. They are bright people. I am sure they could be trained to do almost anything. They could all retrain as coroners if they wanted to do so. So they could be trained. Whether they would want to be trained is a different matter. The fact that medical examiners do not investigate, that we review and then escalate any concerns to the relevant people—and that is not always the coroner; it may be to local clinical governance processes, to the practice manager for general practice, for example—is something that we drill into medical examiners throughout their training. If you find yourself starting to investigate, it has gone too far. It is outside your remit. So it would mean a whole new mindset for medical examiners.

I believe that a lot of them did not go into the role expecting to have to investigate. It is not why they did it. I do not know the motives of every medical examiner, but it is largely to review the medical care that was given, using the experience that they have as clinicians, working with patients, to assess whether the medical care they received was appropriate.

I did a small poll of my medical examiner members last week. I had 65 responses. 81% did not want to be involved in assisted deaths at all. Of

the 19% who said they would, several suggested changes to the rest of the Bill that are not even being proposed as amendments. They were saying, "Well, yes, if this were all to happen, if a coroner were to review the case before death, for example, then I would have no problem with them not seeing it after death". Even those who said medical examiners could review assisted deaths felt that they had conditions through which they would do so.

Several medical examiners also said, "No matter what decision is made, I would refer all of these deaths to the coroner because nothing can make an unnatural death natural, and this is not what I am trained to deal with".

Lord Goodman of Wycombe: At any rate, there is certainly nothing in the Bill at the moment to help them become investigators.

Dr Suzy Lishman: Medical examiners, as far as I am aware, are not mentioned in the Bill. Clause 38 states that these deaths would not be regarded as unnatural under the Coroners and Justice Act 2009 and, therefore, would not require automatic referral to the coroner. They do not mention medical examiners, but, by default, all deaths in England and Wales that are not notified to the coroner must be reviewed by a medical examiner; otherwise they cannot be registered.

Lord Goodman of Wycombe: Can I come back to a point that Lord Patel touched on a moment ago about families? My understanding of the Bill is that the person who requests assisted suicide is under no obligation at all to tell any family members. Is it possible that the medical examiner will be the very first person to tell a family member? It could be a husband, partner, sister, brother—anyone. They could be the person to break the news to this person that their relative has died by assisted suicide.

Dr Suzy Lishman: Yes, that is entirely possible. The medical examiner is often the first person to speak to the family after somebody has died, and that would apply in assisted dying if the family were not involved in the process before death.

Lord Goodman of Wycombe: I asked whether it was possible. Is it likely in most cases?

Dr Suzy Lishman: I do not have the expertise to know what proportion of families would be involved in the assisted dying process.

Lord Goodman of Wycombe: How do you think medical examiners feel about taking on this responsibility?

Dr Suzy Lishman: That is an interesting point, because there has been discussion about whether medical examiners could opt out, as other medical practitioners are able to do, before death. It has not been specified that medical examiners would also be able to opt out with dealing with assisted death, but it is assumed that that protection would cover them as well. I think some would likely opt out because they are

opposed to assisted deaths in general, but I think more would opt out either because they did not want to undergo the extensive additional training that would be required to do it, or because they would not feel that, even with that training, they were the appropriate person to review that death.

Lord Goodman of Wycombe: For those who wanted to opt in, they would need additional new training, would they not?

Dr Suzy Lishman: Significant additional training.

Lord Goodman of Wycombe: Is there any provision for such training in the Bill?

Dr Suzy Lishman: Because medical examiners are not mentioned in the Bill, there is no mention of the additional training that would be required. I would anticipate that medical examiners would need to undergo some of the training that is already offered to those involved in the assisted dying application process, because medical examiners would have to understand that process to be able to review it after death. They would also need additional specific training, which I think would have to come from coroners, because they are the experts in the review of unnatural deaths, and so we would be turning to coroners to help us to deliver that additional training.

Q50 **Baroness Berger:** If I can follow on in the same vein with some questions around the role of families, I have asked about this in a previous session, not because I believe families have the right to make a life and death decision on behalf of their loved ones, but I am concerned that families, including children, will be severely traumatised by finding out that their loved ones had sought an assisted death either very late in the process or even, as we just heard, after assisted death might have taken place, and also because I think family members often have vital information that would help to detect coercion, for example, where a person has a new partner with malevolent intentions.

Given your experience of dealing with family members, as you have just pointed to in the process concerning the medical examination of deaths, what are your concerns, if any, on the points that I have raised in terms of provision on both these counts in the Bill?

Dr Suzy Lishman: Ideally, from a medical examiner perspective, families would be involved before death, so that medical examiners were not the ones breaking the news to them that their loved one had undergone an assisted death. I think there are often multiple family members, and so it is not always clear to medical examiners who has been involved and which ones we should be talking to. Family members may have conflicting views. Some may be very supportive of the assisted death. Some may not. There is also the possibility that the person who underwent an assisted death has a condition that another family member has, and the first they know is that assisted death is something that they may need to start thinking about.

There are so many different aspects that may come out of talking to families that are very difficult to predict. We would anticipate, we would hope, that many people undergoing an assisted death would involve their families, they would have loving families around them, and they would be involved and be supportive of the family.

The thing that medical examiners need to be able to do is to deal with families where that is not the case, and that is not something that we are trained to do. We are not used to doing it. It is coroners and coroner's officers who are accustomed to dealing with these sorts of deaths that are unnatural and due to suicide.

Baroness Berger: Do any of the other panel members wish to contribute to this question?

Thomas Teague: I would like to add one thing to what Dr Lishman has said. Going back to the fact that medical examiners are not investigators, we have to bear in mind that the person—the relative, the partner, whoever it may be—who says to the medical examiner that they have no concerns may be the source of a very serious problem. They may not be telling the truth. The document that appears to show that all the formalities have been correctly complied with might be misleading. If you are not an investigator, you are stuck with it. That is the problem. Investigating that kind of problem is bread and butter to judges and, in particular, to coroners, who are specialist investigative judges. That is the point I would add to Dr Lishman's.

Baroness Berger: I have a specific question about domestic-abuse-related deaths. Domestic homicide reviews, which are now called domestic-abuse-related death reviews, were introduced 20 years ago as a vital way to ensure that lessons are learned from these deaths and that we better safeguard victims in the future, including where a victim has died by suicide. Last year, the Government consulted on updated guidance which notes that a coroner's inquiry can be of considerable assistance as a domestic homicide review may review these and, in some cases, identify evidence of domestic abuse that has not been recognised in other processes.

This Bill will mean that some assisted deaths where domestic abuse is a factor will not be thoroughly examined by a domestic-abuse-related death review, because, under Clause 38, the coroner, as we understand and as we have just discussed, will no longer be under a duty to investigate them and, therefore, vital information will be lost. Can I ask whether the panel members share this analysis and, if they do, what is your assessment of it?

Thomas Teague: I certainly share it, yes. I have nothing to add. This is the whole point, if I have understood what you have just read.

Dr Suzy Lishman: I share the concern. Medical examiners have had no experience or training in dealing with domestic abuse, because, if there was any hint of a non-accidental injury or suicide, the case would have

gone immediately to the coroner, so it is not something we have ever had to deal with.

Baroness Berger: Would you agree that, therefore, this would be a serious step backwards in our ability to monitor and prevent these terrible cases?

Thomas Teague: This is why I used the word “retrograde” before, because there was some discussion earlier in this session about the possibility of training medical examiners in investigative techniques. I respectfully agree with Dr Suzy Lishman’s answer, but we need to remember this. As I said at the start, it has taken us 200 years, ultimately, to get to the position we are now in, the finishing touches to which were only put in place in September of last year, where we have a rational, disciplined, functional system for looking into deaths, for scrutinising deaths, both natural and unnatural.

I am bound to ask: what on earth is the point, when you have reached that stage, of then reversing part of it and saying, “Well, instead of having these unnatural deaths investigated by the coroner in accordance with the system it has taken us 200 years to develop, we are going to put them in another category and then, to get round the problem that they are not being properly investigated, we will train the medical people to do it”? To me, it is frankly absurd.

Q51 **Baroness Finlay of Llandaff:** Can I just follow on a little bit from the family question for a moment? The panel who will be approving the eligibility have no powers to interview the family at all beforehand to explore whether there may be pressure. Indeed, there is no appeal route if one person in the family is aware of coercive control, abuse that has gone unrecognised previously, and so on. With the Bill as it is written at the moment, do you think, from the papers that you would receive of the clinical record and from the panel, that there is any way that you would be able to detect whether there had been coercion to death, pressure to death, abuse or whatever?

Dr Suzy Lishman: Because medical examiners are not mentioned in the Bill, we do not know whether there will be a requirement for papers and documentation to be provided to us. We have a right to request health records, but things such as social care records fall outside those. It is not clear to me which of the records related to the assisted dying process would be available to medical examiners and, even if we had a right to access them, whether the practicalities of having them would be written into the Bill. Perhaps we need to receive all relevant documentation within 24 hours of a death, for example. It is not clear whether that would happen, so we do not know what we are going to get and, at the moment, we are not trained to identify those concerns, so I think it is entirely possible that medical examiners would miss them as things stand.

Baroness Finlay of Llandaff: Could I ask a patient safety question too? We know the current estimated cost to the NHS of harm to patients was

£4.9 billion last year, and there are negligence claims and reported incidents. Do you feel that the assessment process of two individual doctors on a one-to-one consultation, which could be, effectively, behind closed doors, and the data from that going to the panel, would be an adequate way to evaluate whether there has been malfeasance, malpractice, misdiagnosis or whatever?

Professor Aidan Fowler: I am trying to link that and negligence. I am not an expert on the detail. I have not been involved in the detail of the process leading up to death, so it is very difficult for me to comment on that. I think the discussion around clinical negligence is, as you know, a very broad one about what the costs are driven by and so on, and one that we spend a lot of time thinking about separately and is subject to ongoing NAO reviews and so on, so it is a very broad area to comment on. I do not think I have the expertise to comment on the initial assessment as constructed.

I would concur that, from the medical examiner point of view, apart from some who clearly have a view on assisted dying overall, the big concern among medical examiners is their ability to spot coercion in order to then refer it on to the coronial system, and that is the anxiety we would need to deal with. In implementing it, if there was a decision that medical examiners should carry out first scrutiny, we would have to think very carefully, as has been discussed, what provision is made for medical examiners to feel confident that they have the best chance of picking up coercion, should it occur.

Baroness Finlay of Llandaff: Do you have any particular concerns about someone who wished to be an organ donor after their death by an assisted death, and whether that should be treated in any way differently to an ordinary application for an assisted death?

Professor Aidan Fowler: It is not something I have given consideration to.

Q52 **Baroness Berridge:** Following on from that, you may have noticed that, in the Bill—and I have a blend of medics and lawyers here—we have not just got the word “coercion”. We have the word “pressure”. I would be very grateful to know from all three of you: what is your understanding of the word “pressure”, and have you ever had training in how to spot now not just coercion but pressure?

Dr Suzy Lishman: I would understand pressure to mean encouragement to go down a particular route, and coercion to involve some force or threat. I have had no training whatsoever in either of these.

Professor Aidan Fowler: I have not had training in it, and I think it would be the view of medical examiners that they have not had training and would need it to spot it.

Baroness Berridge: I am sorry. Your title is patient safety, so I just assumed, sir, that you had been trained yourself in safeguarding. Is that not the case then?

Professor Aidan Fowler: I am not responsible for safeguarding.

Baroness Berridge: I am sorry.

Professor Aidan Fowler: Patient safety can be a very broad church, and safeguarding sits elsewhere.

Baroness Berridge: I have misunderstood. I am sorry. For the lawyer, have you any idea in law what the word “pressure” might mean?

Thomas Teague: We would apply the dictionary definition. It is a very common English word. I have not got that at my fingertips, but, if it became an issue, you would look it up in the dictionary. It is broader than coercion.

Baroness Berridge: It is broader than coercion, but, in law, when we are basing serious criminal offences on an actus reus of pressure, such as coercion, it would be usual to define that word in law because it can mean different things to different people.

Thomas Teague: It may be. If it forms part of the ingredients of a statutory offence, then it might be necessary. Frankly, I am not sure that it would, because for such a common word in the English language the fundamental principle lawyers apply is to take the dictionary definition.

Baroness Berridge: Yes, I agree, but, under Clause 34 of the Bill, we have a strict liability criminal offence, confirmed by Lord Falconer yesterday, that carries a life sentence imprisonment using the phrase, if you look at Clause 34(1), “A person who, by dishonesty, coercion or pressure, induces another person”. This is contained as a criminal offence. Would you agree that, normally, one would define the word “pressure” if it is included in a serious criminal offence?

Thomas Teague: No, I would not. It is not necessary.

Q53 **Baroness Hayter of Kentish Town:** I was just checking. Is it Mr Teague or Sir Thomas?

Thomas Teague: It is certainly not “Sir”. “Mr Teague” will do fine, thank you, now that I am retired.

Baroness Hayter of Kentish Town: I am just trying to get it right. You very kindly at the beginning did say that what you were saying was your personal view, and I have offered the opportunity to others, which you do not have to reply to—although I have read what you wrote on Policy Exchange that you thought the Bill ran the risk of opening the door to non-voluntary euthanasia—if you wanted to say whether, in principle, you support the Bill or not. You do not need to.

Thomas Teague: I did say, as a recently retired judge, I have to be careful. I did make that Policy Exchange comment and I stand by it. The only clarification I offer is that, of course, I do not mean ‘involuntary’. I mean ‘non-voluntary’. They are two different things, so what I said should not be misunderstood.

I am reluctant to go beyond Clause 38 into my own personal position, and I did notify the committee in advance that I would be reluctant to do so. The only reason is that, as a recently retired judge, I have to be careful in what I say, so that I do not even appear to undermine the independence or the impartiality of the judiciary.

I do have views of my own, but I prefer to keep them to myself, if I may.

Baroness Hayter of Kentish Town: First of all, I just have a comment. We do not all have family. We are talking a lot about family. If I was one of the people in this, there would be no family I could call on, but of course the panel can speak to a family member where that is appropriate. That sums it up in a way for me, because that should all happen, surely, before death.

What is worrying me now is that I do not quite understand—particularly with what Mr Teague said—how after a death somebody could judge whether, for example, someone had changed their mind at the end or they had lost capacity towards the end, because they are dead by then.

What I understand the Bill is trying to do is to have all those checks and balances before the death. I cannot quite understand, after death, if you have been through the two doctors and the panel, and all of that, when you have—and I am sorry to word it like this—a dead body in front of you, what that would tell you that all the safeguards that the Bill has put in would not tell you. Could you try to explain to me what is the missing ingredient that you could find after the death that would not have been investigated before the death?

Thomas Teague: In any case of homicide in the Crown Court, you have—using your blunt expression—a dead body, and no precautions or anything taken, no inquiries made beforehand. It is the job of the criminal court to find out what happened. It is bread and butter, as I said earlier, to judges to do that, and it is no different for coroners in this context.

For obvious reasons—I am not being flippant—you cannot ask the person who has undergone assisted dying, but there will be abundant sources of evidence. If necessary, there can be toxicology tests. There could even be a post-mortem examination. You can make inquiries with the police. The coroner's officers are used to doing that. They do it all the time. They have close connections with the local police force. You can make inquiries with family witnesses, other witnesses. You can ask them to make statements, you can compel their attendance, and you can thoroughly investigate. It happens all the time. The fact that you are handicapped by the death of the person at the centre of it does not prevent you—and need not prevent you—from conducting an exhaustive and successful inquiry.

Baroness Hayter of Kentish Town: It seems to me, therefore, you are describing this as homicide.

Thomas Teague: No. I am sorry; I was using that as an example. I am not calling this homicide. I am pointing out that, in every case of homicide that does occur and is dealt with in the criminal courts, you have the same problem, but the courts manage to deal with it. That is what I am saying.

Baroness Hayter of Kentish Town: But in the case of homicide, the victim from homicide has not been through—first of all, these people are dying anyway. We are only talking about people who are dying, and so the cause of death, if they wait another couple of weeks, will be whatever the underlying illness is, but they are not a victim of someone else's act. They are someone who has taken their own life. You are calling it, if I understand, an unnatural death, but actually it is suicide, which we accept people have the right to do. Do you agree with that—that people have an absolute right to commit suicide?

Thomas Teague: No.

Baroness Hayter of Kentish Town: You do not.

Thomas Teague: No. When the Suicide Act 1961 was introduced, it was not the policy of the law to condone suicide. That is why we have suicide prevention measures. It was said at the time in Parliament, when that Bill was introduced, that the change in the law was not to be taken as in any way condoning the act of suicide. That is why to this day it is still a serious offence to assist in a suicide. So, no, I do not accept the premise at all.

Baroness Hayter of Kentish Town: Suicide is not an offence.

Thomas Teague: No, it is not an offence. This is very important: the reason the change was made was not a change in the public policy towards suicide; it was a change in the criminal law to decriminalise it, because the situation had developed where you could not effectively prosecute the person who successfully committed suicide. What the law was doing was prosecuting people who failed. It was manifestly improper and unjust that people should, in effect, be punished for failing to achieve suicide, but it was always made clear at the time of the debate in Parliament that it would remain an offence to assist a suicide, and that it would be the policy of the law that suicide was not something to be approved of. I am afraid I do not accept that a person has the right to commit suicide. They may not commit an offence by doing it; it does not follow that they have the right to do it.

Baroness Hayter of Kentish Town: Well, we will probably just have to agree to disagree. Could I therefore perhaps turn and ask—sorry, it is Dr Lishman, not Professor Lishman; I have to get these titles right—almost the same question? I know you are sympathetic about it, but the coroners do frighten families. I do not have a family, but they do frighten families. Therefore, for the family, who are supportive, who have gone through all this, who may have been seen by the panel—and as a doctor you believe in a patient-centred approach to this—they have supported

their loved one who is dying anyway, and the death has happened, and then it has to go to a coroner. Do you accept that, for many people, that sort of re-examination after they have been through all these loops really could be another deterrence—and maybe that is why some people want it—to enabling them to go forward?

Dr Suzy Lishman: First, one would explain to the family the entire process, including the process after death, so it would not come as a surprise that a coroner were to be involved. A lot of what we do as medical examiners is reassuring families. As I mentioned earlier, around 30% of deaths are already notified to the coroner, so that is a significant proportion of the families we deal with. What we explain to them is what I explained at the beginning. Coroner referral just means we are notifying the coroner. They can choose whether or how to investigate. It does not mean automatic post-mortem, or inquest, or jury, or any of those things. It does not mean it will delay any of the process and delay the funeral.

A lot of what we do is reassuring families about the role of the coroner, because people do see things on television and do not have a true understanding of what it involves. Many families welcome coroner involvement. When we explain that we need to notify the coroner of a death, many families say, “Good, I am glad. I would like that independent judicial scrutiny of what has happened”. It is reassuring. It is a backstop. It is an end to it, and we have the appropriate people reviewing the death.

One thing I would like to qualify is that an unnatural death does not mean that something illegal has happened or something has been done that is bad. If somebody has breast cancer, for example, and dies as a result of a complication of the chemotherapy that they are given, that is an unnatural death, because it is a result of the medical treatment that they were given. That would be notified to the coroner to investigate. If somebody has a stroke because they are taking blood-thinning medication for a heart condition, that is a direct result of the medication they were given, and it is an unnatural death and would be notified to the coroner.

It does not mean that the underlying cause of death is unnatural—breast cancer or stroke. It just means that in the sequence of events leading to death, there is an unnatural element. There is no suggestion of blame, that the chemotherapy was not necessary or correctly prescribed, or that the blood thinners were not needed. All these things are a balance of the good and the bad that various treatments can do. Calling an assisted death an unnatural death—which for all existing criteria it is—is not implying that anything has been done wrong. It is just giving the opportunity for the independent judicial review that all unnatural deaths have.

Baroness Hayter of Kentish Town: But do you accept as a challenge that—I mean, it may be about language—for a family and the community around them, when someone is dying anyway, for the patient and their loved ones—which may not be family; they may be friends—using the

terminology of unnatural death for something that they consider is natural, because they are dying of the underlying cause, adds another difficulty at a difficult time?

Dr Suzy Lishman: Of course. I understand the sensitivities of that, and it is not something we would come out and say to the families. We would explain to the family that because the medication was involved, for example, in the case of a breast cancer chemotherapy case, the case has to go to the coroner because that is the law. We would not say, "This makes it an unnatural death", and scare the family. We are very sensitive to the feelings of families when somebody has just died. Should the term "unnatural death" be used at any point, for example by the coroner, I am sure it would be explained so that the family understand that there is no pejorative meaning linked to it.

Q54 **The Chair:** Before I go around the committee for supplementary questions, you were very good at the beginning to make some additional remarks to your written statements and so on. I wonder whether there was anything to add to what you said previously. Dr Lishman, would you like to add anything?

Dr Suzy Lishman: I suppose what I have not had an opportunity to make clear is that, should the Bill proceed as currently written, the Royal College of Pathologists would be involved in the training of medical examiners. We would anticipate that guidance would be published by the Government, the national medical examiner from NHS England would provide more detailed guidance for medical examiners, and the Royal College of Pathologists would be instrumental in delivering that training, in close collaboration with coroners, because that is what would be required. We would obviously do our best to deliver that training.

What else did I have to say? It would be helpful to know things such as who would complete the medical certificate of cause of death. I have not seen any mention of that. At the moment, the law states that any doctor who has attended the deceased during their lifetime is eligible to write the cause of death. It would be worth considering whether it is appropriate for any member of the panel to write the death certificate, or whether that should be the GP, palliative care doctor or oncologist who has been treating the patient in the longer term. I have not seen that addressed.

As I mentioned earlier, having clarification about which documents the medical examiner would have access to is very important, because, if they were not to have access to the documentation around assisted dying, they would very much be looking at these with one hand tied behind their back.

The other thing I should say is that medical errors, malintent and other things that can go wrong for patients can happen even to people who are terminally ill, so just because somebody only has six months to live does not mean that their care may not be appropriate, they may not be given

painkillers or whatever drugs they need, so it is important that these are reviewed, even though the person is anticipated to die in the near future.

Professor Aidan Fowler: I would just reiterate that the position for NHS England is that we exist to make sure that people are provided with high-quality, safe, personalised care, and that we have the medical examiner system sitting with us. It is our role, however the Bill is finalised, to take steps to ensure we continue to deliver the medical examiner function to the best of our ability and to deliver high-quality, safe, personalised care. Our role is to enact the will of Parliament.

Thomas Teague: Just two things I would like to add, please. The first is to deal with something I said a few minutes ago, which appears to have caused some surprise: that there is no right to commit suicide. It is an assertion that has the authority of Lord Bingham within the last 25 years who, in the case of *Pretty*¹, said, “The law confers no right to commit suicide. Suicide was always, as a crime, anomalous, since it was the only crime with which no defendant could ever be charged. The main effect of the criminalisation of suicide was to penalise those who attempted to take their own lives and failed, and secondary parties”. That was the point I was seeking to make.

The second point is one that has not yet been mentioned, but it is important, because it should not be assumed that the conduct of an inquest into what is called an assisted death need be at all distressing or add to the distress of families. The reason for that is that we now have two summary documentary procedures for conducting non-contentious inquests. We have had for a long time rule 23, which allows statements to be read at inquests in the way they are often read in other forensic contexts. That can do away with the need for the bereaved or families to attend.

During my term of office, in 2022, a new procedure was introduced called the inquest in writing, where there is actually no hearing. There is an inquest, but it is conducted entirely on the papers, and it is done in private by the coroner in writing. That is only, of course, for uncontentious cases, but, as I understand the Bill, it is accepted by the Bill’s sponsors that, if the case were contentious from a coronial point of view, there would have to be an inquest anyway. For all those other cases where it might be thought there is no real contention, they can be dealt with through these summary documentary procedures. The new bench book for coroners—which came into force I think at the beginning of this year just after I left office, but I did some work on it—specifically recommends that cases of self-inflicted death should be handled, where possible, by means of these summary documentary procedures.

Q55 **Lord Markham:** Thank you, all of you. It has been really helpful for me in terms of understanding. What I have taken away is that you believe that your ability to classify these as unnatural deaths then gives you an opportunity that opens up investigative powers to do it. What I would say

¹ *R(Pretty) v DPP* [2001] UKHL 61 at[35].

is the key difference here, of course, is that we put in place a process where you can make inquiries beforehand and investigative powers. Obviously what we are trying to do is to make the process as safe as possible and put in place safeguards today, which in many cases do not currently exist.

I guess the question is this: in a world with finite resources—and we as a committee have to decide—do we focus our attention and resources in the panel and the work they can do pre death, or do we put the resources and the focus post death? I would say it is much better that we actually focus and put the resources, in a finite world, in making sure the panels are as thorough as possible where there is still time to do something about it and do it pre death. I am not saying that what you are suggesting is not useful after death, but would you agree that, if we had to focus on one area or the other, it is much better that we spend our time focusing on what we can do about the panel and the safeguards pre death?

Dr Suzy Lishman: Nobody would argue with the point that the important thing is to get it right before death rather than after death, but your comment concerns me, because, if all the investment is before death, how on earth are the medical examiners going to review these deaths? We need significant investment and resources to train and appoint medical examiners, because by default, if deaths are not referred to the coroner, medical examiners will have to deal with them. There needs to be investment in whoever is going to review these deaths. There is no suggestion, as far as I am aware, that these deaths would fall outside the medical examiners' remit, so investment needs to be after death as well.

Lord Markham: That was the main thing for me. The main thing is that these are deaths that have been through a process beforehand, which set them aside from any other kind of death that you might be considering.

Q56 **Baroness Smith of Newnham:** You said in your introduction, Dr Lishman, that the idea of a medical examiner came from the Shipman review, so over 20 years ago, but precisely to try to avoid abuses. If we are going to get this legislation right and we want certain practitioners who were perhaps a little keener than others to be engaging in assisting people to die, would it not be particularly incumbent on us as legislators to be making sure that there are safeguards?

Professor Fowler, the Royal College of Psychiatrists has stated that it does not think that assisted dying should be seen as a type of treatment; it should be seen as separate. You have said the commitment of NHS England is a commitment to delivery of care. Do you see assisted dying, then, as part of the care provision, or should we be thinking of it separately?

Professor Aidan Fowler: If it is not part of care provision, I am not clear what it would be.

Baroness Smith of Newnham: The Royal College of Psychiatrists says

it should not be seen as a treatment. They would like it to be seen as a separate provision. Would you envisage setting up new procedures, which would presumably have significant resource implications?

Professor Aidan Fowler: The operational model for how it works remains to be seen. It is difficult for us to lay it out until we have seen exactly how the Bill appears. That is a point we would have to discuss at the time.

Q57 **The Lord Bishop of Newcastle:** Just a brief question for Professor Fowler. Presumably a significant aspect of your role is considering how to build and maintain public trust in the health service, and giving the public confidence that the NHS cares about ensuring patient safety. I wonder if you could briefly comment on whether you have any concerns about the possible impact of this Bill on trust in any of the groups in the NHS.

Professor Aidan Fowler: No, the important thing from the trust point of view is to demonstrate that, were medical examiners, which sit with us, asked to scrutinise these, the appropriate safeguards are in place to ensure that people continue to trust it.

Baroness Finlay of Llandaff: If the role is to sit solely with the medical examiners, would the coroners feel that the medical examiners should have the powers to write a prevention of future deaths report if there was concern?

Thomas Teague: It is a very difficult question, because the prevention of future deaths report is completely geared towards coroners. It would have to be some other mechanism. I cannot envisage, at the moment, a report for the prevention of future deaths being issued by a medical examiner. It has to be done by a coroner who can make the necessary inquiries and has access to all the information. That would be my view.

Dr Suzy Lishman: If a medical examiner identified something in relation to an assisted death that could help prevent future deaths, by definition it would need referral to the coroner.

Baroness Scotland of Asthal: From what I am hearing from both of you, the system that we have at the moment would enable the death to be identified as an assisted death, which would fall into the category of deaths that could take advantage of the written system that has only just been introduced at first instance. The coroner would be able to make an assessment on the written documentation as to whether there was anything untoward in that that would make it necessary to do anything else. It could be a fast process, but it would be one already established.

Thomas Teague: Yes. It would be an inquest, an inquest in writing, but it would not involve the attendance of anybody. It would be done on paper, yes.

Baroness Scotland of Asthal: As far as the medical examiners are concerned, from what I understand from you, if there was an issue in the new system—if that was adopted—it would still have to go to the coroner

anyway.

Dr Suzy Lishman: Yes.

Baroness Scotland of Asthal: Does either of you see any point in us removing the safeguard of the coroner if we are only going to have to put it back in later, and maybe spend more money training those who do not have the legal knowledge and expertise to do that which they were never made to do, created to do, or trained to do?

Dr Suzy Lishman: There would be no point whatsoever.

Thomas Teague: I entirely agree.

Baroness Scotland of Asthal: There is just one thing in terms of death certification. I know that there has been a lot of concern about the term “unnatural death”, because we are using it in a technical term—not in a way we would use for families, but just as a technical identification term. Would it be helpful that we call it an assisted death, to make it clear what actually happened, particularly bearing in mind the sensitivities?

Dr Suzy Lishman: The death certificate itself, I understand, would have the first line of the cause of death being assisted death and the second line being the underlying terminal cause for which the assisted death was sought. The term “unnatural death” is not something that goes on to death certificates. It is essentially a legal term that we use to identify cases to notify to the coroner.

Baroness Scotland of Asthal: It is something that we have used technically, but it is not an attractive thing to talk to people, particularly when they are distressed.

Dr Suzy Lishman: There is no scope for us to use the term “unnatural death” when speaking to families or issuing a death certificate.

Q58 **Baroness Hayter of Kentish Town:** If we leave it, as envisaged at the moment, that it will not go to coroner, I am fairly sure I am right that anyone can refer any death to a coroner—any family member finding out late or anyone. That route would always continue.

Dr Suzy Lishman: Yes.

The Chair: Thank you all very much indeed for coming to see us, and for your very helpful contributions to our session. I have to remind you that the evidence you have given us is taken down and you will be able to see a transcript of it. Would you be kind enough to just check the transcript and draw our attention to any errors in it, which we would need to correct? With that, thank you all very much indeed. I bid you a good afternoon.