HOUSE OF LORDS

Terminally Ill Adults (End of Life) Bill Committee

Corrected oral evidence

Wednesday 29 October 2025

11.40 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. 6 Heard in Public Questions 72 - 82

Witnesses

I: Caroline Abrahams CBE, Director, Age UK; Dr Siobhan O'Dwyer, Associate Professor of Social Care, University of Birmingham; Professor Martin J Vernon, Chair, British Geriatrics Society Ethics and Law Special Interest Group.

Examination of witnesses

Caroline Abrahams, Dr Siobhan O'Dwyer and Professor Martin J Vernon.

Q72 **The Chair:** Welcome to this, the sixth session of our inquiry into the Terminally Ill Adults (End of Life) Bill. We are joined in this session by Caroline Abrahams, Dr Siobhan O'Dwyer and Professor Martin Vernon. You are all extremely welcome and we look forward to your evidence. I think you have all provided us with written statements. If not, I am going to offer you a chance to say something before we start our questioning.

Can I inform you that today's evidence is, of course, being broadcast, but it is also being taken down verbatim? You will be sent the transcript for you to check over and check whether there are any errors. If there are, please point them out to us. I am going to offer you each a chance, if you have a written statement, to add to it and, in the case of Caroline Abrahams, to make a presentation too, but keep it relatively short, because we have a lot of questions to put to you.

Professor Martin J Vernon: I am a geriatrician based in Greater Manchester. As a specialist in the care of older people, I have clinical expertise in caring for older people with complex conditions, including multimorbidity, frailty and dementia. I have an MA in medical ethics and law. Between 2016 and 2019, I was the national clinical director for older people at NHS England. I am here representing the British Geriatrics Society, as chair of its ethics and law special interest group, and lead for assisted dying at the society.

The British Geriatrics Society is currently opposed to the legalisation of assisted dying in England. Our membership comprises people working in healthcare from all the professions across the UK. We currently have 5,600 members working across the entire multidisciplinary team. This includes specialist physicians, geriatricians, nurses, general practitioners, allied health professionals and pharmacists across all healthcare settings.

BGS members wish to bring their skills, capabilities and expertise to improving the lives of older people. A change in the law on assisted dying would have significant impacts on older people and on the work of healthcare professionals who support them. Almost 70% of deaths occur in those aged over 75, and international data from jurisdictions where assisted dying is legalised also demonstrates that most medically assisted deaths are in people over the age of 60.

Last year, we commissioned a piece of work to develop our position. As I have said, that is opposed to the legalisation of assisted dying. This is because we are not confident that effective legal safeguards can be developed to protect older people from harm. We are also concerned that palliative and end-of-life care needs for older people are just not being met. This is not, to be clear, a philosophical position. It is an opposition based on published evidence derived from experience across the world and real-world clinical experience, and the way in which death occurs in this country in health and other care settings.

We have submitted written evidence to the committee, which was developed with our membership, and we continue to analyse the Bill as it has developed. We published a statement in June outlining our ongoing concerns, and particularly do not support the Bill in its current form, based on the fact that it does not safeguard the needs of people with complex conditions, even while trying to protect autonomous choices.

Most people who reach the end of their life are older people who require holistic, person-centred care. We are deeply concerned that the Bill does not require such an assessment, which may identify treatable needs that, if unmet, would otherwise result in an assisted death.

The Chair: I am going to have to stop you there, because we have a lot of questions to put.

Caroline Abrahams: Hello. I am the charity director at Age UK. Age UK is the biggest charity for older people across the UK. We decided, and our board decided, that we should take a neutral position on the yes/no question. That is because we have a well-founded principle of how we operate that, on issues of conscience, where older people might legitimately take very different points of view, we remain neutral, thus our position on the Bill.

We have not sought to influence the Bill. We have been largely leaving it to our friends at the British Geriatrics Society, whose work we think is excellent and incredibly well informed, and we have sought to promote and champion that work where we can. We have also been looking at what the impact already is of the debate, even about this, on what we are hearing and seeing from older people in terms of their behaviour and their attitudes.

I think it would be fair to say that, although we are neutral on the principle, we have very similar concerns, in many ways, to the British Geriatrics Society about the practical operation of all of this. The context against which we are having this debate is one where we have big worries about social care, about palliative and end-of-life care, and about ageism in our society.

Dr Siobhan O'Dwyer: I am associate professor of social care at the University of Birmingham, where I lead a programme of research on suicide and homicide in unpaid carers. That is people who care for family members or friends with long-term illnesses or disabilities. Among other things, that research has included a review of 64 cases of homicide or homicide-suicide perpetrated by unpaid carers, interviews with carers who have contemplated ending the life of the person they care for, and a review of the international literature.

From that research, it is clear that some unpaid carers, both in the UK and abroad, have killed the person for whom they care in an effort to end their suffering, and sometimes in response to an explicit request from the person for help to die. It is not always clear whether the victim's illness in those cases was terminal and, if it was, whether they would have met the

capacity criteria for assisted dying, but it is still reasonable to suggest, on the basis of the available evidence, that making assisted dying legal in England and Wales could prevent some unpaid carers from taking matters into their own hands.

It is also clear from my research, though, that some people in unpaid caring roles abuse the person for whom they are caring or take on caring roles specifically to exploit a vulnerable person for money, goods or housing, and so there must be careful considerations of the safeguards in the Bill to ensure that vulnerable people are not coerced into an assisted death.

The Chair: Thank you very much. Before questions begin, I have two points to make. First of all, one of our number, Lord Markham, is going to have to leave because he has an amendment in the Bill that is going through the House this morning. As a second point in relation to the Bill, it is possible that there will be a Division called, in which case bells will ring and we will have to adjourn for 10 minutes. We will add on time at the end if we lose time because of that.

Q73 **Baroness Hayter of Kentish Town:** Yes, we are not allowed pairing in this House. Thank you very much for your presentations. My first question is to Professor Vernon. I say this partly as someone who is beginning to plan for my 80th birthday. Many of us in this House are slightly worried perhaps that we are categorised as geriatrics, as if we need a whole lot of special help, and some of us may not be in that position. You speak not for us geriatrics ourselves but for the professions.

My question really is about your survey of your membership, because you did not offer a neutral position. Dr Abrahams or Mrs Abrahams—I have forgotten—has said that they remain neutral, but you did not. You only offered for or against, and I am interested about why that is. If I read your data properly, your members were fairly evenly split. On personal views, I think a third—33%—were supportive and almost a third would be willing to participate, should it become the law. I am interested about why you have taken a view that perhaps is not completely reflective of all your members.

Professor Martin J Vernon: The survey, as formulated, was intended to sample at a moment in time the opinions of membership. It was one of the best-responded-to surveys that the BGS has put out in recent years. It did ask for a binary determination as to whether there would be support or opposition from the BGS. We derived, in other questions within that survey, considerably more information about the individual preferences of clinicians.

It is fair to say that the working group we set up last year did glean, through discussions among society members, that there was a very nuanced position. The survey in itself, however, did give us a tip towards opposition at that stage, and that is why we have caveated our present position statement, in that, if there were to be substantial changes—for

instance, legalisation—the society would wish to continue to be involved and would certainly revisit its position statement.

An overwhelming message that came out of that survey, however, was deep concern about the operationalisation of any law to legalise assisted dying, and it was more the practicalities that gave rise to the concern and led to our opposed position.

Baroness Hayter of Kentish Town: I think the response rate was 15% of your members, so a pretty small amount. Could I move to—I am sorry—is it Mrs Abrahams, or Professor?

Caroline Abrahams: You can call me Caroline, if you like. It is fine.

Baroness Hayter of Kentish Town: I can make you a dame if you like. We have seen the ads on TV, but Co-op Funeralcare—maybe I should not advertise it—found from research that the discussion about assisted dying has, it says, helped families to begin to talk about maybe the funeral rather than anything else. Have you found, or your groups found, that we are beginning to find it easier to talk about this, partly as a result of the Bill and other things?

Caroline Abrahams: I will tell you what we have found. We have been approached by older people in two groups—a small number of older people who have come to us and said, "Assisted dying is now a thing. Can I have it?" and a much, much larger group of older people saying, "I am really quite worried about this. Someone has asked me to do something and have a conversation about my future wishes, and I am not going anywhere near that".

Basically, we have found, first, a lot of confusion among our older population about the state of play at the moment and whether it is legal or not—some people already think it has happened—and a great deal of confusion between an assisted death and advanced care planning. We are very for advanced care planning at Age UK. We very much promote it. It is a great thing for older people to think ahead to how they would like to end their time, and all the arrangements that need to go alongside that.

What we have found is that people are being put off from that conversation at the moment, because they are muddled up about whether it is something to do with pushing them into something they do not want to do, and so, as a result of that, we have put out a myth-buster trying to explain what the state of play is at the moment, what the position of the law is, what is likely to happen next, and to try to differentiate for people what is advanced care planning and what is assisted dying.

Baroness Hayter of Kentish Town: That is helpful. Thank you. Dr O'Dwyer, I was interested in your research, because, presumably, you would agree that, at the moment, there are no safeguards at all either if somebody commits suicide or if they go abroad. You have looked at international experience. What are your lessons from that about how

having safeguards is better than not having any safeguards at all?

Dr Siobhan O'Dwyer: It is difficult, because there has not been any research that has compared rates of family members taking matters into their own hands before and after the introduction of legislation. It is almost impossible research to do, but certainly from what we see in the evidence, what we hear from family members we talk to who have thought about helping the person to end their life, I think the safeguards are absolutely important.

Baroness Hayter of Kentish Town: Therefore, it would be an improvement, do you think, from what we have now, where, as I say, there are no safeguards?

Dr Siobhan O'Dwyer: I think so. At the moment, there are families who feel that this is their only option—to take matters into their own hands. We are not going to prevent all homicides perpetrated by families, but there is a subset of them that we would absolutely prevent if the legislation was in place, but the safeguards are important to prevent people being coerced by carers and family members who are already abusive prior to this.

Q74 **Baroness Berger:** Thank you all for being with us today. I have two specific questions, please, to Caroline Abrahams. First, I note that, two years ago, Age UK campaigned successfully for the Office for National Statistics to collect data on older victims and survivors of domestic abuse for those aged 75 and over. I am sure we would all want to congratulate you on that important data collection. Do you believe, on behalf of Age UK, that the Bill includes adequate safeguards to mitigate the risk of domestic abuse towards older people?

Caroline Abrahams: Not really. It is really hard to think about how you can do that. That is the problem. It is a really difficult thing to do in our society. As for what we did with that campaign, it was as though our society thought that domestic violence was something that happened only to younger people, and we know now that it is quite a hidden problem among older people and it can happen in lots of different ways, perpetrated by lots of different people, but it does not stop just because you reach a certain age.

As I say, the difficulty is that it is hidden, it is behind closed doors, and most of our systems and processes in the UK, which are there to detect and to help people who are victims of domestic violence and abuse, are more geared to the assumption that it will be younger people, so it is quite hard for older people. One of the ways it is often detected is when someone goes into hospital, so people like Martin are some of the people who are most likely to be able to realise that it is going on through something that is said or not said, or behaviour of a person. I find it very difficult to see how you could put safeguards in from that point of view, or for other forms of coercion, to be honest. It is just a really tough thing, because sometimes these things are really subtle, they are very hidden, and it is behind closed doors.

Baroness Berger: Do you have any views about anything specific that should be amended in the Bill to address this very serious concern?

Caroline Abrahams: Not as such, because we have not sought to follow the passage of the Bill in detail or to look at amendments from that point of view. We know that the Secretary of State has the power to create codes of practice on various topics, but, on how we could ensure that older people in particular do not feel under pressure to make a decision that is for reasons other than their own real choice, that is the nub for us, I think, but that is a hard thing to get at.

Baroness Berger: My question just now was specifically about violence and domestic abuse, which is very serious. If I can ask you about another type of abuse of the elderly, which is around financial abuse and in particular romance fraud, I am interested in the threat posed by new partners—for example, those seeking to inherit from a will or those who target vulnerable people through catfishing and romance scams. People set up fake online personas and pretend to form a romantic relationship with someone in order to extort money from them.

I have noticed that the discussions about the Bill so far have very much focused on an assumption that, where people are at risk of coercion, undue influence or abuse, this is only really likely to come from immediate family rather than partners. I wondered whether Age UK has a view about how prolific this issue is of older people meeting new people, or dating, including online. Does it make it harder to detect these forms of abuse? Do the processes outlined in this Bill adequately ensure that coercion related to romance fraud can be identified?

Caroline Abrahams: Again, we know it happens. I do not think anybody knows how prevalent it is. Again, it is often a hidden problem, but we see the reports in the media about it. We are occasionally contacted more often by families who say, "Hang on, I'm really worried that there is this person in my mother's or father's life and I'm not sure what their intentions are".

This all gets very mixed up with the fact that older people have assets and money. There is an enormous moral hazard around lots of issues to do with social care, as a really good example, where there is a moral hazard for people who stand to gain from older people after their death. That is one of the things I worry about the most about our social care system, in a world in which, if an older person owns their own home and lives in the south, whoever is going to inherit that, that is a transformational amount of money for many people in our society in a way that nothing else is, unless they win the lottery, which is rather unusual and unlikely.

That is the backdrop to this. There is already a moral hazard caught up with anything to do with inheritance, frankly. Again, I do not know that there is a way of being able to guard against that really effectively. You are right: romance fraud is a potential problem. I do not know how the Bill would be able to put in place processes to detect that, but it is a

much bigger and wider issue than that, and it is to do with inheritance more generally, I think.

Dr Siobhan O'Dwyer: Could I add something there? I think there are safeguards in the Bill already in Section 52 around a relative, around someone who is already named in the will. To your point around, "What if it's not a family member?", there are some things that could be added potentially to Section 52 around someone who is cohabiting with the person, someone who is in a romantic or sexual relationship with them, or someone the person believes themselves to be in a relationship with.

Certainly in our research, there is a group of people who we see killed by a carer who has been exploiting them. In some of those cases, the carer knows they aren't in a legitimate relationship with the person they are exploiting, but they have convinced the person they are exploiting that they are. Some additional points around disqualifying witnesses or proxies on the grounds of a romantic or sexual relationship, or cohabiting, could help address some of those concerns.

The Chair: Mr Vernon, do you have anything to add on this point?

Professor Martin J Vernon: Yes. Among older people, we know that the overall prevalence of abuse in all its manifestations is around about 4%. Financial abuse, as we have already heard, is particularly difficult to identify. While Caroline has referenced contact with health and social care professionals as key points for decision-making around financial planning for older people, particularly when they are in need and may consider themselves to be a burden, trying to put in place any infrastructure at the moment, although we do have safeguarding procedures, is extraordinarily difficult.

It often does not detect the problem, and I think we have already heard that, within complex dynamics of a family, which may be not all in evidence when these decisions get taken, there are very few mechanisms that we have to access or understand how financial abuse might be occurring, because much of this remains hidden to health and social care professionals, who do have opportunities but are very limited in how they can safeguard the individual at the centre of this.

Q75 **Lord Markham:** Really building on that point, my understanding is that there are high levels of public support among elderly people for the assisted dying Bill. I have seen it somewhere between 60% and 80%, so very, very high levels. My understanding is also that, of course, today, what you are referring to is the lack of safeguards that currently exist. This Bill does put a number of safeguards in place, and the job of this committee is to review that and make sure that it is appropriate. Also, my understanding is that the benefit is that it has already initiated a conversation among elderly people about their wishes in death, and conversations about wills, which is a natural part of that.

We are comparing this Bill to the status quo, where there are not many safeguards in place. Surely, then, the safeguards that we are looking at

here are a good thing, in that we are making it safer.

Professor Martin J Vernon: Shall I speak to that?

Lord Markham: I mean particularly Caroline, because she was talking about it.

Caroline Abrahams: Sorry, I was not quite sure who your question was directed to. Yes, I take your point, but I am not sure our understanding of the overall point of view about this is quite the same as yours. We worry that the problem with this is the broader point too about people feeling under pressure to make decisions that they otherwise would not want to make, either because of what is really quite close to home and quite personal, and because older people worry a lot about what is going on for their younger relatives and do not want to make life even harder for them. Money is often short and, if someone is going to live longer and it is going to cost them a lot to look after them in terms of their social care, that is less money for other things, so we worry about that.

We worry about the lack of choice about whether you are going to get good social care or good end-of-life and palliative care. That is another problem. We worry about a sense that, over time, it can exacerbate a feeling that an older person's life is not worth as much as a younger person's. Those are the kinds of things that worry us.

It is an extraordinarily difficult situation and state of affairs. I know you are thinking about this very, very hard, and we are not wishing at all to deprive people of making a choice that is right for them. The problem is how you ensure that really is the case and it does not have unintended consequences more broadly across our society and for our older population.

Lord Markham: In some ways, does this not bring in Dr O'Dwyer's work as well? You are saying that, unfortunately, a lot of these conversations or these things are happening undercover, for want of a better word, and driving some people to then extreme circumstances where an unpaid carer does take a life, often with good intentions. I think that is what your work is showing, is it not, Dr O'Dwyer? Bringing this out into the open more and trying to build in some safeguards surely is a good thing.

Dr Siobhan O'Dwyer: I think so, but there are also more safeguards that could be put in place. I am particularly interested in Section 12 of the Bill, which talks about the assessing doctor. At the moment, it is up to the assessing doctor's discretion as to whether they seek any additional information about that person's life or well-being. There is no mandate on that doctor to speak to people in social care, to see what sort of support that person is getting, to speak to police about whether there has been a history of domestic abuse.

I think there is quite a big presumption in the Bill that medical professionals are always aware of what else is going on in someone's life, where they are accessing services and what information those services

might hold. There is scope to build in some additional safeguards by making sure that those assessing doctors get a better sense of the whole picture, particularly through engaging with social care providers.

Lord Markham: Would we all agree—to bring you in as well, Professor—that this whole conversation and this whole process, by bringing light into the situation, is a positive thing as well? By bringing them up, then we have opportunities to address these things that, right now, are often happening under wraps.

Dr Siobhan O'Dwyer: Yes, I agree.

Professor Martin J Vernon: There is no question about the need for safeguards. It is more about the adequacy of those safeguards. As my colleague has already mentioned, the execution of those safeguards and the depth and breadth of inquiry that would be necessary, particularly among the assessing doctors, is much broader than is currently contained within the Bill. There is virtually nothing in there that sets out their qualifications and training.

Again, in Clause 8(7), there is an opportunity for the Secretary of State, via regulations, to make provisions about that, and the British Geriatrics Society would be very keen to see that include the holistic, multi-dynamic, multicomponent assessments that are necessary to understand an older person's situation towards the end of their life, and that would include their social health, cognitive and mental health needs.

Some of these things are referenced within the Bill already, but there is precious little about the wider setting of an individual when they may be making a decision about assisted death. Specifically, a safeguard that we would suggest could be brought in through that Clause 8 would be the requirement for those doctors to have adequate training in that wider domain. This is what geriatricians do for a living—work with multidisciplinary teams to undertake those assessments and understand the whole picture that sits around that individual at the time of decision-making.

Q76 **The Lord Bishop of Newcastle:** I have a couple of lines of inquiry, please. Thank you very much to panel members for appearing before us today. The Government's impact assessment on the Bill laid out the savings that could be made to health and care services if someone received an assisted death and required four fewer months of healthcare, and care and support.

I appreciate this is not the intention of the Bill's sponsors or of the Government, but I wonder, Professor Vernon, Caroline Abrahams, whether either of you has a concern—I think, Caroline, you mentioned this in one of your answers just previously—that older people's lives may be seen as less valuable as a result of introducing this Bill.

Caroline Abrahams: Yes, absolutely, I do. Over time, in a very resource-constrained environment, where there is not enough money to do everything we need to do, I worry that, insidiously, the view starts to

take hold that perhaps it does not matter quite so much now around social care or palliative care, where, in both cases, we are miles away from where we want to be or ought to be, and I do not see any immediate prospects of that changing. So, yes, I think that could be the case and we would be really worried about that.

Professor Martin J Vernon: If I could follow up on that, increasingly through population ageing in the country, we are seeing a move, and other countries have already experienced this shift, towards net dependency driven by the older population—people who are economically inactive, who place significant demand on the health and social care system. Any suggestion of ending life earlier than otherwise might have occurred naturally could create pressure within the system for individuals to do that in order to reduce that demand on health and social care, which, at the present time, is increasing in an unsustainable manner, placing huge economic burden on the country. That is a very real and present threat.

The Lord Bishop of Newcastle: Briefly to each of the panel around different cultural considerations of older people, the work of Dr Jamila Hussain and others has highlighted the importance of considering the needs of minoritised communities. I wonder whether you have done any work to highlight how safeguarding issues for older people vary across communities. Does the Bill sufficiently account for cultural differences, or differences in attitudes to death and trust in health and care systems?

Dr Siobhan O'Dwyer: My one concern around that is the use of interpreters. We know that, particularly in small language groups or faith communities, often the interpreter is a relative, or is someone known within the community, so that would be a concern there for me about how accurate the information is that is going in both directions.

Caroline Abrahams: We at Age UK recently published a report called *Aging while Black*, which looks particularly at the experiences and views of older African-Caribbeans in our society. One of the things we found there was markedly less trust in the NHS, in doctors, in nurses, and problems in accessing services more broadly. I cannot say whether that has been taken into account in terms of the creation of the Bill, but you are quite right to raise this, and that is just one small example. There are different attitudes and different experiences among groups of older people of accessing health care.

Professor Martin J Vernon: Work we have done within my own professional group and, indeed, within the national NHS has identified that the prevalence of frailty—a characteristic of poor-quality ageing, loss of biological resilience, and increased likelihood of end of life and social dependency being reached—is much higher in rural, ethnically diverse and poorer populations, particularly coastal areas. Where there is deprivation, where there is lack of access to health and social care services, where there is significant cultural and ethnic diversity, those people are not going to age as well as others, and may well feel the greater sense of burden that I have just referenced.

Q77 **Lord Goddard of Stockport:** Thank you to the panel for attending. I read all the reports and the submissions that you have given, and Dr O'Dwyer's was, for me, the eye-opener, because I think you have lifted a stone there that people probably do not want to look underneath. That was around carers with best intentions thinking they are doing the best thing, and other people with ulterior motives who are not doing it for the good reasons. The unintended consequence is the same: that person dies and some people will benefit from that going ahead.

What I am trying to explore—and I am learning and listening as I go along—is that there seem to be no safeguards at the moment regarding older people and how older people are looked after in palliative care. I have heard from other members today about catfishing and all these other things. I will not be betrayed by anybody romantically to try to get their hands on the money I may or may not have at the end of my life, but I can see exactly how that would work. It is about how we build those safeguards in, because what we are trying to determine on this Select Committee is not whether it is a good or a bad thing, but how we can make this Bill better and more efficient, and build those safeguards in.

Really, I am just trying to explore with the three of you what initial things would make that safeguarding better, but I just also wanted to say and put on the record this is not an end of life Bill for old people. This Bill is for any person who is terminally ill with less than six months to live, and that is not specifically for older people. It is other people as well.

We need to have cognisance of that when our discussion seems to be completely focused on it being older people, and they are vulnerable and need extra care, but the safeguards within this Bill, even requiring improving, are a thousand times better than what we have at the present. I am not asking you to comment on that, but just what would you think you could offer—the three of you—that would make this Bill safer for older people, and would enable us, in a report to the House of Lords, to put those things forward as perhaps amendments?

Dr Siobhan O'Dwyer: For me, it is probably the two things I have already mentioned. First, it is around Section 52—who is disqualified from being a witness or a proxy—and adding in additional criteria there around people who are living together, people who are or have claimed to be the provider of unpaid care, anyone who is in a romantic or sexual relationship.

It is also Section 12, around making sure that the assessing doctor is mandated to consult other professionals.

In Section 22, there is talk of an independent advocate for people with learning disabilities and autism. Maybe everyone should be entitled to an independent advocate.

Professor Martin J Vernon: If I could just address the older persons issue, the reality is that the majority of people who die in this country are older people. The leading cause of death in this country is dementia, over

and above cancer and cardiovascular disease. In other jurisdictions, for instance Canada, where assisted dying has been legalised, the majority of users—85% plus—of medically assisted deaths are older people over the age of 65, so it is most certainly an issue most likely to impact on older people.

With regards to improving the safeguards, there are two things, I think. I have already referenced that the training, qualification and assessment of people electing to choose assisted dying needs to be broadened to include training in those safeguards, which we have already discussed is multi-dynamic, multicomponent, and hidden among other elements of care, not necessarily visible to a single individual, including a doctor.

Also, within the Bill, there is an opportunity to put in a code of practice through regulations. While we have already sought in the Bill to protect people with mental health conditions, adults with a learning disability, there should also be, I suggest, a code of practice specifically relating to older people as the dominant users of an assisted dying service, we would expect.

Caroline Abrahams: It might just be helpful for me to say that there is an adult safeguarding system in our country. It is run by local government. It is really busy; it is somewhat overwhelmed. As you would expect, Age UK hears from lots and lots of older people. We have a national advice line. I think we get between 800 and 1,000 calls a day. Some of those calls are from people who give us cause to think that they might be at risk for one reason or other. We always refer, of course, to the local authority. Sometimes we get a good response and, at other times, they are just too busy.

The context again for this is a system in which adult safeguarding is under acute pressure because local government is under such acute pressure. There is definitely something to be said for a social worker to be involved in assessing somebody's situation and trying to look at those issues around risk, but, again, it is not an easy thing to do.

Professor Martin J Vernon: If I could just add to that, there is currently a backlog of 123,000 people in England awaiting statutory assessment for deprivation of liberty safeguards to be put in place. Those are people who are currently, therefore, technically being unlawfully detained.

Lord Goddard of Stockport: We heard from carers at a previous hearing. I come from a local government background, and it is frustrating when you do not have the means and the wherewithal to assess people quicker. The problem with this is that this particular Bill is talking about people with only six months left to live. By the time it goes to a local authority and it is in a backlog of hundreds per individual local authority, the time might pass anyway.

The broader picture there for Government and the message I am getting is that palliative care needs far more money invested in it, a bit more

cohesive thinking about how to deliver the service, and a need to include people like you in the thinking, because you are the doers. You are the people at the sharp end who know, rather than the Ministers in Whitehall who just dictate the policies. This Bill, if nothing else, as I started the conversation with, has opened the light to the real need to have a look at palliative care, working in partnership with whatever else comes along.

The Chair: Would anybody like to answer?

Caroline Abrahams: Sorry, I was not sure it was a question.

Lord Goddard of Stockport: It was a slightly rhetorical question.

Professor Martin J Vernon: Yes is the answer.

Q78 **Baroness Finlay of Llandaff:** I have questions for each of you, but, if I could start off with Professor Vernon, we have heard from others that the six-month prognosis is remarkably inaccurate and has a less than 50% accuracy. From the population you are involved in looking after, do you feel that that applies, or do you think we could put legal certainty around that six-month prognosis as stated in the Bill?

Professor Martin J Vernon: The short answer is no; we cannot put legal certainty around prognosis, and the six-month life expectancy is particularly problematic. Most of the work on prognostication has been done in single diagnosis around cancer, where we have well-described disease trajectories, albeit with better treatment and modification.

Prognostication in a single diagnosis such as a cancer diagnosis is notoriously unreliable. Doctors and health professionals are very good at predicting when somebody is going to die within one to three days. They are also very good at predicting when somebody is likely to survive beyond one year. In between those times—a few days to one year—it is almost impossible for a doctor to give an accurate prognosis. There is at least a 20% to 30% unreliability in those predictions, and the tendency within doctors in particular is to overestimate the prognosis. That can cause a number of problems within this Bill that somebody may expect to live longer than they really do or, alternatively, may choose to end their life earlier, based on information provided.

Prognostication is extraordinarily difficult. I have only mentioned single diagnosis and, again, going back to the dominant users of an assisted dying service in other territories, we will be looking at people with multimorbidity, multiple long-term conditions, frailty, dementia, where prognostication is extraordinarily difficult.

Baroness Finlay of Llandaff: You raised dementia, and this Bill is being promoted on the back of pain and suffering, although it says nothing about it in the Bill. The public out there often think that this Bill will apply to people with dementia, but my reading of the Bill is that it will not. I wonder what your comment is on that and on people who may have fluctuating capacity. Perhaps you and Caroline might want to answer that.

Professor Martin J Vernon: Shall I go first?

Caroline Abrahams: Please do, yes.

Professor Martin J Vernon: The early stages of dementia are perfectly compatible with retaining capacity, but, none the less, a diagnosis of dementia or any other neurodegenerative condition is likely to predispose a person to at least transiently losing capacity following acute illness. Delirium is extremely common in hospitals. Depending on which bit of the hospital you are using, its prevalence can be up to 80%, and recovery from that can be delayed.

In the context of somebody with a neurocognitive condition such as dementia, it is extremely likely that this may be characterised as a progression of that illness when in fact it is not, but is a recoverable circumstance. This raises another issue about the definition of terminal disease within the Bill. Yes, fluctuating capacity is an extraordinarily common issue, but none the less somebody may retain capacity at some point during their dementia diagnosis sufficient to make a determination as to whether they wish to end their life.

Caroline Abrahams: I do not really have anything to add to that.

Baroness Finlay of Llandaff: When Caroline Abrahams was speaking, she suggested that the problem of coercion and domestic difficulties overall is often picked up only when patients are admitted to hospital. I just wonder in your experience whether you feel that our primary care system needs to be strengthened, because at the moment home visits are quite rare and yet, when you do a home visit, you often see a very different picture from the one that you see when the patient comes into hospital. Should we require that a home visit is undertaken and that safeguarding is looked at as part of the initial assessment?

Professor Martin J Vernon: Yes. We have seen a shift in NHS policy in the last year towards greater use of digital means and this is driven by the Covid pandemic. However, we know from experience during Covid that an awful lot happened behind closed doors. Assessing somebody remotely, digitally, without a face-to-face assessment, particularly if they have complex health and social care needs, is nigh-on impossible. So trying to do so remotely and via digital means is infeasible.

There has been a significant shift in my specialism towards providing those home care assessments, but you are absolutely right: the infrastructure of community services and primary care is in such a poor state at the present time that we cannot rely on those assessments being done in a comprehensive and a holistic way, and there is often reliance on people such as me to support that.

Caroline Abrahams: Probably the thing that we hear most of all from older people would make the biggest difference to their lives would be easier access to their GP. There are lots and lots of older people who are struggling to get any access to their GP, to be honest. Of course, there is

the issue around digitisation that Martin referred to. There are also GP practices that do not do home visits at all. I cared for my mum for more than three years. We had hardly any contact with the GP at all, and that is not that unusual. There is a statistic that significant numbers of older people, as they reach the end of their lives, do not have any actual contact with their GP.

Baroness Finlay of Llandaff: Can I just ask a question to Dr O'Dwyer? If I understood correctly from looking at your work, you have done an in-depth study with 64 cases and you categorise them into seven different groups, potentially. I wonder, of those, how many you found where actually it was a homicide because the person had asked for their life to be ended and whether that was upheld with a coroner's verdict later on.

Dr Siobhan O'Dwyer: Within those seven categories, one was about ending suffering, so where we believed that the unpaid carer was driven by desire to end the person's suffering. In about half of those cases, there was a request for help to die or the person had had a very clear death wish; they had talked about their own desire for suicide. When those cases are a homicide-suicide, it is very difficult to have any evidence about that, whether there was a suicide pact or anything else.

In several of the cases where the carer was prosecuted, the judges did agree that the person had asked for help to die. Interestingly, in very few of those cases that were prosecuted were they charged with assisting suicide. They were still mostly charged with murder, or they were convicted of manslaughter on the grounds of diminished responsibility or loss of control.

Baroness Finlay of Llandaff: Can you put a number on those? You have 64 cases overall.

Dr Siobhan O'Dwyer: No, not off the top of my head, but I could let you know. I suspect it is about eight in that category and then about half who had expressed a wish to die or had asked for help. I can check for you and let you know.

Baroness Finlay of Llandaff: We are probably talking about around four.

Dr Siobhan O'Dwyer: Yes, I would guess so.

Baroness Finlay of Llandaff: I was interested that you are very clear about the need for the police to be contacted. That has often been a concern: that, where there has been domestic strife and pressure of all sorts, the other parts of the system have not known about it, although neighbours may and have possibly phoned the police, or other family members may.

Dr Siobhan O'Dwyer: Yes, absolutely. Building on your point about GPs, even if you have a great relationship with your GP, there are whole parts of your life that your GP knows nothing about and that social care organisations will. Going beyond local authorities in terms of social care

and thinking about charities, carer charities or disability-specific charities are much more likely to know what is going on in someone's life.

There are also the police. We know there are lots of people who experience domestic violence who never press charges but call the police because the police showing up puts an end to the acute episode of domestic abuse. Police will have records on callouts to homes and that should be checked when someone is requesting assisted dying.

Baroness Finlay of Llandaff: Could I ask one more question of Professor Vernon? We have heard of other situations where people may have a desire for death but, when they have excellent specialist palliative care, that desire for death goes and they have a desire to continue living. In the population you are seeing, how often do you find that patients, when they arrive with you, are in despair over their whole situation and that sometimes the diagnosis is wrong, reversible causes have been missed and their whole perception on living can change?

Professor Martin J Vernon: That unfortunately is an extremely frequent occurrence. The whole premise of geriatric medicine in its modern iteration is that a full, comprehensive assessment, looking at all aspects of a person's physical, cognitive and mental health, social setting and economic circumstances, yields better outcomes. We very frequently see people presenting themselves to the health system in crisis for various reasons, not just a health crisis, and showing up in hospital because that is the only place that they can go. Often there are very many remediable interventions that improve that person's circumstances to recovery.

We are limited in our capacity and capability to provide rehab and restorative services in the country, despite best efforts of the health service to do that over the last decade or two. None the less, those interventions presently are highly effective. It is not unusual for me as a practising geriatrician, and I work in the acute end of the system with emergency departments, to see somebody brought in in extremis and to be able to get that person home within a few days with restorative care.

Q79 **Lord Winston:** There has been a lot of talk about dementia here in this conversation, but, as I understand it, this Bill would not apply to people with diminished mental capacity anyway, so that really is irrelevant in this discussion. One thing that is important, though, is that, although the Bill allows for up to six months, as calculated, and we accept that these calculations are very indistinct, the key issue for many of us around this committee table is the issue of severe suffering in the last few weeks of life when it becomes apparent that really there is no future for that patient living. The problem we have is that the safeguards that are needed in this Bill are not absent but are really quite excessive in many ways.

For example, could I ask each of you to tell me what you feel about the need for a panel to assess each patient who undergoes this procedure? Do you feel that is really necessary in this Bill? If we are trying to

improve it, would that be an improvement, if we left this out or tried something else? What do you three think about that? Professor Vernon, could you start on that?

Professor Martin J Vernon: If I could just mention the first point that you made, with regards to dementia, that does not preclude a person having capacity at all. In the early stages of dementia, people often retain capacity for health and welfare decision-making, so a dementia diagnosis does not equate to loss of capacity at all. However, a dementia diagnosis may precipitate somebody who does not understand the trajectory of their illness making an early election to assisted dying, in the absence of any foreseeable care and palliation to their symptoms.

Lord Winston: I accept that.

Professor Martin J Vernon: To turn to the point about the time scaling and the existing safeguards, that is indeed problematic, whereby the time delays that may be entailed in going through a bureaucratic procedure—we have already said that existing bureaucratic procedures around other aspects of safeguarding are extraordinarily delayed—could miss the opportunity for that individual to execute their autonomous choice.

That is a real issue, and there is a balancing point between having an effective safeguard that protects those individuals who may have vulnerabilities and supporting them to make an autonomous choice versus those people who may escape the system and not be safeguarded at all. I do think having an overburdensome bureaucratic process that actually obstructs somebody's autonomous choice is against the spirit of this Bill.

Caroline Abrahams: It is a balancing act, just as Martin said. I know the original intention was to have a judge. I quite like that, as an ex-lawyer. I think judges are very good at making decisions. Instead of that, we now have a panel of several people. While I am not an expert in this area at all, it feels to me as though you need something, but how do you do it in a way that makes it as rapid and unbureaucratic as possible, for all the reasons that Martin just said?

Dr Siobhan O'Dwyer: I agree; it is a really difficult tension, but, given the absence of any representation of social care in the Bill until it reaches that point where there is a social worker on the panel, I would be very concerned about taking that out, because it then means that the only people making decisions and assessing for information are medical professionals, and I am not convinced that they have a full understanding of what is going on in someone's life to adequately assess whether they have been coerced or pressured. I would be very concerned about taking that out.

Lord Winston: One of the issues, Professor Vernon, is that there are far too few geriatricians in this country. Indeed, I have been an in-patient in a hospital for three separate surgical procedures in the last year. I never saw a geriatrician, and that would be quite typical, but actually probably

wrong. Clearly, the involvement of geriatricians in this kind of procedure would seem to be relatively useful and robust. Would you like to comment on that?

Professor Martin J Vernon: I would entirely agree with both points. There is an inadequate supply of designated geriatricians in the country. Even though we are training more, demand is exceeding supply at the moment. None the less, the specialism of geriatric medicine relies upon multidisciplinary teams, and we have the capability in the country and are, indeed, in some aspects of geriatric care, expanding the workforce in other ways. There is opportunity for the health service to build its own workforce outwards using other professional groups. However, within this Bill, there is only reference, really, to doctors being involved in this.

The care of older people is entirely a multidisciplinary sport involving allied health professionals, pharmacists, nurses, advanced clinical practitioners, who increasingly are becoming quite dominant in my own field and highly effective. If we were to broaden the field of assessment and the number of professionals involved, that would answer some of the concerns that you have raised.

Lord Winston: It would not be an impossible amendment, certainly, to put that in at some stage. Thank you very much indeed.

Q80 **Baroness Smith of Newnham:** Thank you. I have not standardly declared any interests because technically, according to the rules of requirement to declare interests, I do not have an interest to declare. But I think, for the purposes of this session, I should state that my father is currently in hospital, but is otherwise resident in a nursing home. Therefore, many of the topics we are talking about are highly personal, so I thought I should just put that on the record.

My questions are again about safeguarding. My colleague Lord Goddard has suggested that there are no safeguards at present and the current proposals are 1,000 times better than what we have at present, and yet, in your written statement, Dr O'Dwyer, you suggested that, for carers who essentially are not assisting people to die, the risk of prosecution has been a key deterrent. The safeguard at the moment, or a key safeguard, is that it is illegal to assist a suicide. If we change the law as proposed in this legislation for the purposes of assisting somebody with a terminal illness, the situation would change in limited circumstances.

On the basis of her research, does she have any concerns that, rather than reducing the dangers of homicide, the changes could actually increase the dangers of homicide? At the moment, the suggestion is that those people who are assisting relatives are doing so for altruistic reasons and, therefore, prosecutions have been very limited. If we are opening up the scope to all members of society with a terminal illness and a prognosis of less than six months, the nature of the conversations could change and older people in particular might be put in a situation where conversations are much more prevalent and make them feel under pressure or coercion to consider an assisted death.

Dr Siobhan O'Dwyer: There are a few parts there, so I will try to go through them step by step. First, these cases, when they happen, are being prosecuted. Very rarely does the DPP decide not to prosecute, even if the motives are altruistic. Even, I would argue, sometimes when it is not in the public interest to prosecute, they are prosecuted. Actually, I think the offences set out in the Bill at the moment, as it stands, would absolutely deter well-meaning and genuinely caring families from pressuring someone to request assisted dying.

Where the offences currently set out are not going to be effective is where that family relationship is already abusive or coercive, but I think no offence deters that. We see that already. People are abusive and coercive, and the threat of prosecution and jail time does not deter them. For well-meaning families who genuinely care about their family member who is terminally ill, I think the deterrents are sufficient.

The point about aged care, though, and nursing homes and care homes, is a really interesting one. There is no mention of it in the Bill at the moment, so presumably people in aged care, in care homes and nursing homes, are able to access this. I noticed that the legislation in Queensland in Australia specifically sets out some guidance around ensuring equal access to assisted dying for people in aged care facilities. That is something that may need some more consideration here.

Baroness Smith of Newnham: As a follow-up, particularly, I suppose, to Caroline, you have already suggested that there are many calls to Age UK, including those who may be feeling under pressure. Do you think that the draft legislation is likely to increase those concerns, and are there safeguards that are not currently in the Bill that we should be considering?

Caroline Abrahams: It is impossible to say, to be quite honest. We hear from people who are ringing up because they are a bit worried about Mrs Bloggs next door, or they saw something in a shop, or whatever it might be. It is all kinds of different situations. It is not particularly about someone feeling coerced into doing something they do not want to do.

I think what is the case, though, is that, as currently constructed, this starts to normalise the idea of somebody choosing to end their life in a way that is risky for some older people in some situations, against a context in which the provisions in place to support one to have a natural death are so patchy. It is the imbalance between those two things that I am conscious of, and we would worry about, I think.

Now, it would be fantastic if this debate was leading to an enormous upsurge in political media and public interest in sorting out social care and sorting out palliative and end-of-life care, but I am not seeing that at the moment. That would be a compensatory measure that would completely level the playing field. That is the difficulty at the moment. It is not a level playing field. For too many people, it is really hard, as you start to approach the end of your life, in terms of the amount of support

you are able to access. If we could change that, that would be brilliant, and it would change our view about the balance at the moment, I think.

Q81 **The Chair:** Before I open the session up to supplementary questions from the committee, I wonder whether any of you would want to add anything in the light of our discussion so far.

Professor Martin J Vernon: I just want to make a point, drawing off the discussion about coercion. It is one thing safeguarding against coercion in a closed, relational environment, such as within a family or between friends and neighbours. It is another thing to try to introduce safeguards around the negative messaging we have in our society around the burdensome nature of ageing.

We have a very negative narrative in this country around ageing as being deleterious and regressive, and there is very little narrative around positive and supportive ageing, yet, as I have referenced earlier, we do have a need to support better-quality ageing, and in fact we know how to do this, to some extent. There is a danger that some people who are burdened by illness, loss of capability and capacity, loss of social support, loss of connectivity, may feel subtly pressured and coerced into ending their life earlier than they might otherwise have done.

That cannot be ignored in a societal shift through new legislation that enables something to happen, which people may well have considered, particularly on a dark day, because of their own circumstances. It goes back to Caroline's point about the lack of alternative supports we have in our society to encourage and support better-quality ageing right through to the end of life. There is an opportunity here for us as a country to improve our offers around palliative support and end-of-life care, for sure, but perhaps the bigger opportunity is to improve the quality of ageing better in our society so that we value older people more.

Caroline Abrahams: As you would expect, I love that point. At Age UK, that really speaks to what we think as well. We are far too negative about getting older at the moment. Because life is really hard for lots of people of all ages, there is a bit of a tendency to blame older people for that as well sometimes, which is not really very helpful or fair in our view. Yes, again, this is another unfortunate moment against which these discussions are happening, really, because we think that growing older is a privilege and one that many people enjoy.

Baroness Hayter made the point herself. Life is for living, and we want everyone to get the most out of life, from the beginning to the end. Trying to inculcate more of that sort of feeling, while having this conversation as well, would really do a service to the public.

Dr Siobhan O'Dwyer: The only other thing I would add is around awareness, so making sure, if and when the Bill becomes legislation, that families in particular are very clear about what the Bill allows and does not allow. Caroline said she had had phone calls. I have certainly spoken to carers who think that, if the Bill comes in, that will allow them to end

the life of the person they are caring for. Those of us in the room would understand that that is not what the Bill is saying at all, but I think, in the general public, there is some misunderstanding. If and when the Bill becomes legislation, there should be a very clear awareness campaign around what is allowed and what is not allowed.

Q82 **Baroness Scotland of Asthal:** I really wanted to take up the evidence, Dr O'Dwyer, that you have given, because I thought it was quite stunning in many ways. You had 64 cases and only eight of those were cases where the individuals who ended the person's life thought they were doing it to help them. The other 56 cases were people who were ending the person's life for unacceptable or pernicious reasons. That is what your research showed.

Dr Siobhan O'Dwyer: "Unacceptable" and "pernicious" are strong words. I would say for different motives or different driving factors. We certainly see there is also a group of carers who kill because they are so totally overwhelmed by the caring role. They cannot see any other way out. They want to end their own life, but they cannot imagine leaving the person they care for behind because of all the problems we have talked about in health and social care, and so they decide it would be kinder to end both lives. It is important we recognise those as well.

There are other types of homicides perpetrated by unpaid carers that are about exploitation or about domestic abuse. But it is also important to recognise that that abuse can go in both directions, so it can be the carer abusing the person they care for, or it can be the carer being abused by the person they care for.

Baroness Scotland of Asthal: And therefore they end their lives. You set them out really very well and it is very worrying. Nine involved caregivers with pre-existing mental illness or neglect. We are looking at only eight, if I can put it that way, where the people doing it actually think they are doing it because it is needed or wanted; it could even be considered to be perhaps loving.

I understand your issue on that, but what I was concerned about is that you said, in relation to what in effect are the DPP guidelines in this country, that in fact there were 199 cases since 2010 that were referred. Of those, 133 were not pursued. There are only 10 that are being pursued and eight of them were referred for homicide, but the rest were dealt with differently. Is that your understanding? It seemed to me that you were suggesting—

Dr Siobhan O'Dwyer: Sorry, I am not sure I understand what those cases are. I assume you mean cases prosecuted for assisting suicide—that number.

Baroness Scotland of Asthal: These were cases that were referred for consideration for prosecution—199 cases. Of those, 133 were not pursued.

Dr Siobhan O'Dwyer: Of assisting suicide, sorry?

Baroness Scotland of Asthal: Of assisting suicide. Then, of those—and this is since 2010, so in the last 15 years—10 are currently being investigated, but only eight were referred for actual prosecution for homicide.

Dr Siobhan O'Dwyer: We are not comparing apples with apples here. I think some of those assisted suicide cases will not have been people who were in a caring role for that person. In our research, people had to be providing care for someone with a long-term illness or disability, so that naturally will not cover all assisted suicide cases. Also, in that particular piece of research, we looked at a five-year period. I suspect, had we looked at the same 15-year period, we might have seen different things, so I think it is not the right comparison.

Baroness Scotland of Asthal: I absolutely accept that. I think it was a comment you made, and I may have misunderstood you, where you were saying that there was an inappropriate prosecution of those who were in a family and who were trying to be helpful in terms of ending life. I may have misunderstood you.

Dr Siobhan O'Dwyer: No, I think you are right. I am not sure I would say inappropriate. I guess my question is around whether it is in the public interest to spend time, money and resources prosecuting a case where there is no risk of reoffending and no threat to the wider community. It is also important to recognise that the cases in our research are across the lifespan, so they are not just people who are terminally ill; they are also mothers killing profoundly disabled children, for example, and then being prosecuted for that when there were clearly system factors involved. The bit that is specific to terminal illness is different from the research as a whole.

Baroness Scotland of Asthal: I suppose I was trying to reassure you that, under the DPP's guidelines, the DPP, together with the Attorney-General, is responsible for exercising discretion as to what is in the public interest. I was trying to reassure you that those guidelines are working and there are not prosecutions that would not be in the public interest to prosecute because they are being exercised properly by the Attorney-General and the DPP, just for reassurance.

Sitting suspended.

The Chair: We are resuming our session, I am afraid, to terminate it because time has run against us and we have no more time for any further questions. On behalf of the committee, we would like to thank all three of you very much indeed for your evidence, for coming here and giving us such assistance on this very delicate subject.

Can I remind you that a transcript will be available for you to check for accuracy? If there are errors, please let us know. Good afternoon and thank you so much for coming.