



Terminally Ill Adults (End of Life) Bill Committee

Corrected oral evidence

Thursday 30 October 2025

10.15 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. 8

Heard in Public

Questions 97 - 109

Witnesses

I: Professor Jane Monckton-Smith OBE, Professor of Public Protection, University of Gloucestershire; Dr Sarah Hughes, Chief Executive, Mind; Cherryl Henry-Leach, Chief Executive, Standing Together Against Domestic Abuse.

Examination of witnesses

Professor Jane Monckton-Smith, Dr Sarah Hughes and Cherryl Henry-Leach.

Q97 **The Chair:** Welcome to this, the eighth session of our inquiry into the Terminally Ill Adults (End of Life) Bill. We are joined at this session by Professor Jane Monckton-Smith, Dr Sarah Hughes and Cherryl Henry-Leach. You are all very welcome and we look forward to your evidence. You have each provided us with written statements, for which we are very grateful and which we have all read, but there will be an opportunity for you, when you introduce yourself, as I am going to ask you to do, to say a few words more, if you would like to do so.

Today's meeting is being broadcast and a transcript of the proceedings will be taken for subsequent publication. It will be sent to you so that you can check to see whether your evidence as recorded in it is accurate. If you find anything that is wrong in it, please let us know and we will do our best to correct it.

I wonder whether, first of all, Professor Monckton-Smith, you would care to introduce yourself and say anything in addition to your written statement that you would like to say.

Professor Jane Monckton-Smith: I am a professor of public protection at the University of Gloucestershire. I do have some things that I would like to say, more reiterating what I have already written, but I think they are so important that I would like to do that.

The Chair: Please do, but be quite brief because we have a lot of questions to put to you.

Professor Jane Monckton-Smith: Yes, I recognise that. There are three things I want to talk about. The first is domestic-abuse-related suicide and the scale of that particular issue. We have only just started counting these deaths in the last 18 months or so, but the most recent research suggests that potentially up to 34 people take their lives as a result of domestic abuse or linked to domestic abuse every week in the UK. That is a substantial figure.

I would also like to say that there is developing knowledge with our professionals at the moment—there has been knowledge around this in the academic world for a long time—around the issue of homicides being staged as suicides. Now, that might sound as if it is quite a niche issue. It actually is not. The global research is telling us that the most likely way a homicide is going to be staged is via a suicide.

I would also like to mention the recent coronial findings that are linking domestic abuse, coercive control and suicide. They are making causal links and that is having a huge impact on the way that we understand coercive control and its role.

Just to keep it very short, I would like to finish by saying what the key question is for me. Is the person trying to escape the abuse and feelings that they have been made to feel a burden or are they trying to escape

the suffering of their illness? If we cannot answer that question, then we should be very concerned.

Dr Sarah Hughes: Thank you to the panel for inviting me and Mind here today. I am chief executive of Mind. I will make some introductory remarks, but I hope that many of our concerns will be raised during the session.

First, we really understand that there are many deeply held and complicated views about this debate on both sides. We take that incredibly seriously and we consider it carefully. We have not considered it our place to decide on whether assisted dying is right or wrong, but we have considered our role in terms of safeguarding, the protection of individuals and whether the Bill provides adequate safeguards.

We do think that this Bill must be considered within the context of health inequality. We do want to help the committee understand that we have concerns in relation to the distinction between the definition of terminal illness and some of the mental health conditions, including anorexia and others.

We are really concerned about the prospect of the eligibility widening in the future. We have seen that happen in other jurisdictions.

We want to see a very clear distinction between any assisted dying legislation and suicide prevention efforts. As somebody who has worked in mental health for 35 years, I can certainly tell you that we are geared up to prevent suicide, not the other way around.

The voices of people with mental health problems and those treating them and caring for them must be heard. People living with a mental health challenge must be able to thrive in their own lives. They must be supported by health and social care in the way that they deserve. We do not believe that is the case across England and Wales at this moment. I will leave it at that for now and hope other comments will be covered.

Cherryl Henry-Leach: Good morning. Thank you for inviting me on behalf of Standing Together Against Domestic Abuse. I am the organisation's chief executive. We are a national charity committed to ending domestic abuse. To do that, we work across a number of sectors and communities to achieve safe and effective ways of identifying and responding to domestic abuse while holding perpetrators accountable. This includes our work within the health sector, housing and criminal justice. We also support domestic-abuse-related death reviews.

Our organisation does not have a position on whether Parliament should legislate on this issue, but we are very grateful to this committee for enabling us to share with you our concerns that it will be very difficult to deliver assisted dying safely in the context of current systems, which are not properly equipped to identify and respond to domestic abuse victims, survivors and perpetrators.

We are also concerned that the Bill in its current format will place undue pressure on the professionals, particularly health professionals, who will be assessing those who make requests under this potential legislation.

Coercion is an incredibly complex phenomenon and by its very nature it is difficult to identify and respond to. A perpetrator of coercion will ensure that a person is dependent on them by isolating them from support, exploiting them and depriving them of their independence and autonomy to make decisions freely. As a result of this, we are extremely concerned.

We echo the concerns raised by Professor Monckton-Smith and Dr Hughes this morning because we are concerned that victims of abuse whose abuse has not been recognised or responded to prior to a confirmed diagnosis of terminal illness—

The Chair: Can we leave it there, please? We have a lot of questions and I do not want to run out of time for the questions.

Cherryl Henry-Leach: No, that is fine. I will leave it there.

Q98 **Lord Goddard of Stockport:** Thank you for coming today. I think the Chairman said this is the eighth session of evidence. For me personally, this is one of the most important sessions that we will be taking in evidence of the 11 that we are doing.

Could I ask the panel initially to reflect on this question? At the moment, we cannot be sure whether the people deciding to travel abroad for assisted deaths are being coerced into doing that. We also do not have any data on how many people choose to refuse life-sustaining treatment or assessments to ensure that those decisions are voluntary. That is not set out in statute. Any wrongdoing is only exposed and investigated following a death. What are your reflections on the status quo, as it stands now?

I will then perhaps move on to a different question about how we can move forward, but I would just like to hear your views. I will probably allow Cherryl to finish what she was saying before the Chairman quite rightly curtailed her.

Cherryl Henry-Leach: In terms of the current system, I think it is a fair reflection to share with you that we believe very firmly that there are no checks and balances to ensure appropriate levels of safeguarding. That includes a person's decision not being influenced by a perpetrator.

We are also concerned that those whose diagnosis has been confirmed as terminal, if there is pre-existing domestic abuse prior to that diagnosis, may be coerced to feel that their condition or illness is a burden to their perpetrator because of the dynamic of the coercive control that they have suffered prior to that diagnosis. We would feel that it is an unsafe system that we have at the moment.

Dr Sarah Hughes: I would concur. I think that we absolutely know we have limited safeguards, actually, for people who want to leave the

country for assisted dying support. We also know that many people do take their own lives. That is nearly 6,000 people a year.

It is for that very reason that we think that, in order to provide legislation that allows it in this country, all the levers and safeguards that we have need to be developed and evolved significantly to ensure those safeguards were in place.

We have coercive control legislation. I think that is incredibly important. Of course, that is still fairly new in terms of the world of health and social care, criminal justice and so on. In terms of being able to understand how effective it is on every level, we are still in the early stages of that.

However, people with mental health challenges are incredibly vulnerable to coercion. We know that from all the evidence that we collect, not only from Mind but from other sector colleagues and organisations. While we see that this legislation could provide an additional layer of safeguarding, at the moment the levers that are proposed to do that, the Mental Capacity Act and the panel, do not seem sufficient either.

Professor Jane Monckton-Smith: The examples that you gave at the moment are informal ways. If we are going to introduce a Bill that sanctions this formally and says, "This person has chosen and we are going to allow this to happen", that is a completely different context, is it not? You will actually be assisting, potentially, the perpetrator.

Lord Goddard of Stockport: That leads me into my second question. As the Bill stands at present, there are five separate assessments for eligibility, including voluntariness. Where there are doubts about capacity, the Bill mandates a referral to a specialist. If you introduce a new offence of coercion, it mandates training in coercion. Are there any other end-of-life serious clinical decision-making processes that have similar safeguards? What would you like to see in the Bill, as you have just indicated to me, that would offer people who are dying the choice while protecting those who are eligible? What further safeguards would you, as three clinicians, want as a minimum to add to this Bill to protect against the coercive elements of the Act?

Professor Jane Monckton-Smith: Personally, I would like there to be an assumption, perhaps, that you have to prove there is no control, not establish whether there is. It is such a huge problem. Domestic abuse has been declared a national emergency, especially violence against women and girls and vulnerable people. At the moment, I do not think that exists.

My reading so far has been that the person who wants to prematurely die will have to state that they are not being coerced. We already know that people who are being coerced will more than likely deny that they are being coerced for that very reason. I would want to see steps taken, not in an elongated way, at least to gather evidence even of somebody's partner's history or something like that. You could establish that it is not

there rather than saying, "We're going to ask you and, if you say no, we're going to accept that".

Dr Sarah Hughes: The question is incredibly important. From our point of view, there are a number of things. We really feel concerned about the quality and amount of training around coercion and the impact that would have on the professionals we would need. We already know that there are many instances where our ability as a system to assess coercive control is compromised; it is not at the level it should be. In such an incredibly grave decision, that feels precarious.

I think we would also say that individuals need advocates. While there is a panel and there will be various assessments, the person really does need an independent advocate at every point to be able to understand the information that they are being given, the conversations that they are having and so on. It is really interesting that the panel will offer an important stage, but we do not think that is comparable to having a judge. While we do not think it is an either/or scenario, we do think it is a both scenario.

Cherry/ Henry-Leach: These are important questions. Within our written submission we have made a raft of recommendations. If I may, I will just summarise them very briefly. We are recommending that there is a multidisciplinary assessment framework to enable partnership working with domestic abuse specialists to identify whether there is a pre-existing pattern of coercive control within the relationship dynamic. We would ask for a robust definition of coercion and that, within Clause 36, there is a code of practice to enable identification and support of that.

We would ask that training in regulation is mandatory, covers all professionals, including the voluntary assisted dying commissioner, and is taken beyond e-learning, perhaps to in-person training, to effect cultural change. We also would ask that the safeguards should be embedded and protected within the Bill at every single stage, so they underpin the decisions that are made.

The Chair: Thank you very much. I think we must move on.

Q99 **Baroness Smith of Newnham:** Thank you very much for coming this morning to this very important session. I have one question initially for Professor Monckton-Smith and then a question for all three of you, if I may.

Professor Monckton-Smith, I gather that you were initially due to speak to the Public Bill Committee in the House of Commons and were not able to do so. I wonder whether you could tell us what you might have said then and whether you think the changes to the Bill that have been introduced since January have actually changed your opinion of the Bill.

Professor Jane Monckton-Smith: I am very pleased to see that domestic abuse and coercive control is being taken very seriously. That is really good, but I have not changed my mind on the Bill thus far because, having worked in this area for a very long time now, in domestic

homicide reviews, for example, when things go badly wrong, they will say, "Let's give them more training. Let's give them more training". Throwing that at something clearly does not work. We have to have a process in place where we actually know what it is that we are looking to establish.

Dr Hughes talked about being able to define our terms. I do not think that has been done well enough. I do not think capacity has been considered widely enough. I do not think it has been considered really how important this is in the context of suicides that are happening right now in incredibly high numbers, actually, and how this might make that worse.

Baroness Smith of Newnham: My next question is to all three of you. It follows on, in large part, from the responses to my colleague Lord Goddard. The Bill in Clause 17 has various points about showing that the decision was reached voluntarily and that people were not coerced or pressured. At the moment, the Bill suggests that the panel is required to hear from the person to whom the referral relates, or their proxy in applicable cases, either in person or via live video or audio link, or, if the panel considers it appropriate, to use pre-recorded audio or video material. Do members of the panel feel that that is an adequate way of understanding whether an individual is being coerced?

Professor Jane Monckton-Smith: No. In a word, no. It is not the method necessarily, whether it is online or whether it is in person; it is who you are talking to. If you are talking to somebody who is saying that they want to take their own life or end their life prematurely, they might not be the only person you would want to speak to about whether they are being coerced. If the panel is about the panel and that person, that does not change anything for me. There should be some background checks.

Dr Sarah Hughes: I absolutely, again, concur with that. We absolutely would not consider that an adequate safeguard. From the point of view of somebody who would be experiencing mental health challenges at that point, I think it would be very difficult to understand that that would give them an opportunity to freely be open and well supported. At the moment, they do not have an advocate, for instance. There are all sorts of dynamics, I think, at that point.

I would also say, in addition, though, that I do not think you can adequately assess people's emotional state online. With such a grave decision, that is a huge risk.

Cherryl Henry-Leach: I concur with my colleagues. I would also signpost you to research undertaken by the Mayor of London's office in 2019 that indicates that 10% of cases where there was a domestic-abuse-related death involved a carer as a perpetrator. In 2024, a review of domestic-abuse-related deaths indicated that in over 50% of cases healthcare professionals had not identified domestic abuse as a feature in the case.

For me, hearing what Dr Hughes and Professor Monckton-Smith have said, I absolutely concur. I do feel that it would be inadequate to assess a person's emotional state online, particularly when we know from research that a patient may not be able to identify that they are a victim of domestic abuse, given the very subtle dynamic that develops when coercion is a feature.

Q100 Lord Markham: What I think I have heard from all of you, which I completely understand, is that in the current situation we have up to 34 suicides or deaths, and there are not appropriate safeguards in place in the process today and an underground system, for want of a better word, that happens. As I understand it, this Bill is trying to bring that out into the open. I believe that all doctors have to be trained in being able to understand coercive behaviour and we are trying to put safeguards in place, which I think we would all agree are much better than the status quo. They might not be perfect, but they are definitely a better situation than the status quo.

The difficulty that we have as parliamentarians, if I can share our world with you, is that right now we can either try to pass this Bill, which brings it into the open and puts additional safeguards in place versus the status quo, absolutely taking on board your own opinions on how we can improve that, or we can vote against the Bill and see the status quo remain, and all the problems that you are talking about in terms of underground coercion go on.

Those are the choices that we have in front of us. I am interested in your advice to us. If you put our hats on, if you were in our shoes, what would you advise us? If those are the choices, would you say, "Pass this Bill with the safeguards" or, "Keep the status quo"? Those are our choices. There is not a third choice.

Dr Sarah Hughes: I think it is a really difficult position for you all to be in. I absolutely honour that. We are not here to kind of criticise or judge. I think it is a really important debate.

From our perspective, we are really clear. We do not take a position on whether the assisted dying Bill is right or wrong. If, however, the Bill is going to go ahead, it has to go ahead with improved safeguards. I am not going to suggest "don't do it" because I think we are probably further along than that. However, it is really clear that the safeguards described in the current Bill are not adequate.

Because of the issues around coercive control, the issues around the mental health challenges and the fact that the definitions are not yet sophisticated enough, we feel we cannot support it in its current form. From that perspective, we would need quite a lot more to be able to support it.

Professor Jane Monckton-Smith: I appreciate the really difficult position you are in. I know that there are many people who feel that there are a lot of people out there who would benefit from this Bill. If I

were taking that decision—and I am not—I would be very concerned about saying yes to something where I thought, “Loads and loads of people might die, where we could have improved their lives rather than them dying”. I would feel very, very concerned about voting yes to that.

Lord Markham: Again, thank you all. It is a difficult question, I accept, but we have to face it. Thank you for your honesty.

Cherryl Henry-Leach: I certainly do not envy the decision that you have to make. I would echo that we do not have, at Standing Together, a position on whether this legislation should be passed or not. We do have concerns that the safeguards within the Bill at present are not sufficient to support those who are being coerced, particularly those who will be at their most vulnerable within our society.

Again, I would signpost you to the recommendations that we have made in our written submission, which include early identification through routine and sensitive inquiry away from family members to enable discussions with patients in a meaningful way. We would also, again, request that there is mandatory training, beyond e-learning, for all professionals involved in the process. For us, it is about supporting the wider system to support those professionals in the decision-making that they have to do.

Lord Markham: I have one follow-up. We are talking about, of course, in this case, people who are already terminally ill and diagnosed as within six months of dying. There is, obviously, experience of this abroad as well. Australia, New Zealand and Canada have had very similar issues. Domestic abuse occurs there as well and I suspect that they face very similar situations. Is there any evidence we can draw on there? Is there evidence that their assisted dying legislation has improved the situation or made it worse? Are you familiar with any evidence at all that we can learn from?

Dr Sarah Hughes: Our understanding, from a mental health perspective, is that, in the jurisdictions where assisted dying has been supported, the definition has widened to include people with mental health conditions. That is a primary concern for us. That expansion of the definition is problematic.

We would also say that we are not convinced that the evidence is robust enough to help us understand what implication it has on the system. We do know that there is emerging evidence that increasing numbers of people are taking their own lives in those jurisdictions. It is too early to tell, but that is part of the issue, really. We do not really understand, in terms of the status quo, how this legislation will improve people’s experiences of end of life.

Lord Markham: Again, maybe this can be a follow-up because you might not have it there. I am not aware that it has increased overseas. I would be interested in the evidence. That would be very helpful.

The Chair: Lord Markham, forgive me. We should move on. We may be able to come back to this later on.

Q101 **Baroness Scotland of Asthal:** First, thank you very much for your very powerful evidence. I just want to make sure I have correctly understood it. At the moment, domestic violence is the greatest cause of morbidity in women and girls globally and certainly the greatest cause of morbidity in women and girls in our country.

I was very concerned by the figures you gave. As I understand it, there are two ways out, quite often, for those who are at high risk of domestic violence from their perpetrator. Either they get killed or the other option they take, if they cannot stand it, is to take their own lives. Those are the two.

I am right in saying, am I not, that we have been trying to train medical and other professionals to better understand coercive control since 2004? I see all of you nodding. That is particularly the medical but also the legal and other professionals involved.

Am I also right in saying that that training has not, as yet, made the sort of impact on the figures that would cause us to believe there is going to be a reduction in the number of deaths? You are all nodding. If you say yes—

Dr Sarah Hughes: Yes.

Cherryl Henry-Leach: Yes.

Professor Jane Monckton-Smith: Yes. You are right.

Baroness Scotland of Asthal: Further, we had not investigated the level of suicides. A very high proportion of the 34 people who are taking their lives every week take their lives because of the situation they find themselves in. If we now look at the safeguards that we are being asked to approve, particularly bearing in mind the suggestion of training, do you think that training is likely to have a significant impact on the figures that we are now seeing? If we adopt the safeguards in this Bill, is it going to work, from your experience?

Professor Jane Monckton-Smith: I will just start with that one. First of all, training is a very broad brush. Will there be any oversight of what that training consists of? Is this training in suicide prevention? Is this training in trying to identify a pattern of coercive control? Those are two completely different things. Sometimes when we say “training”, we just think, “That’s it. That’s good enough”, and we do not look at the content of that training or what the outcomes might be. Thus far, training has not been particularly successful—I will absolutely agree with you—but I do not think that enough attention has been paid to what the outcome of that training is actually supposed to be.

Baroness Scotland of Asthal: A number of you have talked about the multiagency risk assessment conference—the MARAC—and the

independent domestic violence advisers. We know that those two structures have helped us to reduce the number of domestic violence deaths or better understand the risks. Are you suggesting that a similar multiagency risk assessment approach would be necessary, if we were to make an impact in this area as well?

Dr Sarah Hughes: Yes, that would be an additional safeguard, of course. The people who are often around that table are highly qualified individuals and well trained.

In terms of the issue of training, the way it is described currently is absolutely not adequate. We know from our experience in very many areas that even some of the most highly qualified social workers and doctors find it incredibly difficult because it does raise a change in practice. It raises significant shifts in the way you undertake assessments and engage with family, friends and supporters of the individual.

Bearing in mind that we have been doing it for such a long time, you would hope that we would have seen the impact that we wanted to see, but, as Professor Monckton-Smith said, the reality is that we are not following training through an outcomes evaluation approach. We train people, send them off into the world and hope for the best. We really need a much more regulatory framework to understand whether people are maintaining practice.

Baroness Scotland of Asthal: Are the safeguards that are being proposed safe for those people we are talking about or not?

Dr Sarah Hughes: No.

Baroness Scotland of Asthal: If we look now at what the likely consequence of such a change is going to be, I have heard you say that there is a worry about almost a cultural change or a shift. If this were to come in, how would you stop that shift from taking place? Would it make it better than where we are now or potentially worse than where we are now, bearing in mind that where we are is not good?

Professor Jane Monckton-Smith: I do not really understand the question.

Dr Sarah Hughes: Are you asking whether this is better than nothing or is it deeper than that?

Baroness Scotland of Asthal: Let me make it simple. What would we need to do to make the position that we are currently in better? Is this Bill it?

Dr Sarah Hughes: That is a great question, and thank you for asking it. From my perspective, I certainly think that safeguards across the board need a huge elevation, as it stands.

Absolutely, we have to accept that in all sorts of areas it is not just inadequate but neglectful and potentially scandalous. Anything that we

do obviously has to be focused on improving the experience that people currently have.

Is this the Bill for it? I cannot necessarily say. In its current form, we are not entirely convinced that it will offer that additional layer. It feels like there are too many potential loopholes or subjectivity, which is worrying.

From our perspective, it very much depends on how we can get this Bill tighter, being clear in terms of advocacy, being clear on the definitions, the steps that people are taking and who is supporting them throughout those steps, and being clear on the training, the quality of the training, the evaluation and the constant monitoring of those outcomes.

The Chair: Professor Monckton-Smith, you were agreeing with that, I think. You were nodding your head, were you not?

Professor Jane Monckton-Smith: I was agreeing with Dr Hughes, yes.

Baroness Scotland of Asthal: From the transcript's point of view, we cannot see the nod. It was clear that all three of you are of the same mind and are in agreement.

Cherryl Henry-Leach: We are. If I may just briefly add, we would also ask or recommend that there is a co-ordinated assessment that spans a range of agencies but includes domestic abuse specialist support and advice to ensure earlier identification of abuse. That can enable consideration as to whether coercion has been levered on the decisions made.

Q102 **Baroness Hayter of Kentish Town:** Thank you very much. Some of us are so old, we started on domestic abuse working with Erin Pizzey before you were all born. Someone mentioned 34 people taking their lives at the moment. We are, of course, talking only about people who are dying—probably, when it finally happens, in the last two or three weeks of their life. We are talking about a very small subset. I think it is important to hold that. That is what we are talking about.

I would like to make one comment first. Someone raised the issue of anorexia. I think you will all know that there is an amendment down to Clause 2(2) to ensure that no one with anorexia would fall under the scope. I assume you would all approve of that amendment. Again, they are nodding.

Professor Jane Monckton-Smith: Yes.

Cherryl Henry-Leach: Yes.

Dr Sarah Hughes: We must remember to do that, yes.

Baroness Hayter of Kentish Town: A number of you have said you still do not think there are enough safeguards. We are talking about two doctors having seen the patient before. If either or both of them have any concerns in regard to mental ability or health, or whatever, they have to refer to a psychiatrist. It then goes to a panel, which will include

a psychiatrist, and all of the panel will have been trained in coercive control.

I am finding it quite hard to imagine how many more layers you want. I have a fear that you are putting in so many extra layers that the people who do not have a mental health issue, who are dying and in considerable suffering, will actually be denied what they want. Is that a concern for you? There will be a group of people who, if you are not careful, will be excluded from this because of your absolutely correct worry about actually quite a small number of people for whom domestic control might be an issue?

Professor Jane Monckton-Smith: There are a couple of things I would like to say. You say you are talking about a very small subset of people. You say people with only three to four weeks to live. Is that correct? Have I got that right?

Baroness Hayter of Kentish Town: Sorry, that is those who finally will use it. They are eligible to start the process once they are in the last six months of their life, but that only begins the process. The process is likely to take a quite considerable time. I am just going through all the layers. What we know from abroad is that, even once they have gone through all of that, they do not use it straightaway. Of course, about a third never do anyway. That is why I am talking about quite a small subset. The people who are dying have started the process, which they can do only in the last six months. It will take them some time to go through, and then they will not necessarily avail themselves then but when things get really, really difficult at the end.

That is what I mean. From what we know from abroad, it is really towards the end that it is actually exercised, even though they can enter the pathway earlier on.

Professor Jane Monckton-Smith: Victims of coercive control, of course, are not a small subset of our community. We also know that, when victims of coercive control get a life-limiting diagnosis, they become even more vulnerable at that point. Domestic abuse tends to rise. They tend to get left, if they are being abused or neglected.

Yes, that is actually a real concern for me. We know that domestic abuse victims are getting palliative rather than curative care because of the neglect that they have suffered in the relationship and getting their diagnoses late.

Baroness Hayter of Kentish Town: Can I pause you there? That is really interesting. Do you have published evidence about that?

Professor Jane Monckton-Smith: Yes.

Baroness Hayter of Kentish Town: I do not think we have seen that. It would be really interesting. Apologies.

Professor Jane Monckton-Smith: Because of those things, I have serious concerns. Of the small subset of people about whom you are very concerned—I absolutely agree you should be concerned—what percentage might also be victims of coercive control? That is our concern.

Baroness Hayter of Kentish Town: With the safeguards that we have put in, at least five people will have seen them. Are you wanting more people in addition to that or more layers? What are you wanting to add to the five people who will already have considered this?

Professor Jane Monckton-Smith: Two doctors, you said. If those doctors have concerns, then it gets referred to a psychiatrist and a panel. In the first instance, it is two doctors.

Baroness Hayter of Kentish Town: It must be the panel. The first extra psychiatrist is optional. It is two doctors. If there is a problem there, it goes to a psychiatrist. Then it goes to a panel, which also includes a psychiatrist plus two other people who have been trained in coercive control.

Professor Jane Monckton-Smith: As I think we have discussed, it is quite a thorny issue to say you have been trained. Have you been trained in identifying coercive control? Is there a responsibility on the people who are assessing whether there is coercive control? What is their responsibility? As I said in the beginning, is it to ask the person and accept their answer?

I have worked in this area for a very long time. I have seen victims refuse medical help when they have been hit in the head with a hammer through fear. That is not an isolated example. If you speak to the other people here, I think they will probably agree with me. What I am saying is that coercive control is a serious social problem. It will impact on the people who are going to look to this Bill.

Baroness Hayter of Kentish Town: I am out of time, so I have a very quick question.

The Chair: Dr Hughes, you were nodding your head.

Dr Sarah Hughes: Yes.

Baroness Hayter of Kentish Town: Dr Hughes, I would like to ask a specific question to you. If this Bill goes through, we would have about four years before it would be implemented. Therefore, with the experience that not just the three of you but all your colleagues have, would you be willing, in that period, if it were to go ahead, to help put in your experience so that the regulation, the guidelines and all that training could be made in a way that was fit for purpose from your point of view?

Dr Sarah Hughes: Certainly, we would absolutely want to be advocating for the people we care about the most at any stage. Whatever happens, we will be alongside the Bill, alongside you, and making sure it is the safest it can possibly be.

To the point around what more we could put in and whether five is too many, I have worked in mental health for a long time and been involved in lots of Mental Health Act assessments. I worked alongside Sir Simon Wessely during the Mental Health Act review. This issue comes up a lot. "If we put in more safeguards, that is a delay" et cetera.

I am afraid that does not, in some ways, land with me in terms of the reason why we would not add additional safeguards in terms of time, even in the circumstances you have identified. This is because of the matters that we have raised already to do with coercion, but we have not talked about racism within the system, systemic inequality and the particular issues around certain groups who are incredibly vulnerable in terms of coercion.

We also know that even five people can get it wrong. Those five people can all have the same training and deliver and implement the training in different ways. For us, it is about the quality of the interventions. It is about the quality of the training. It is about the quality of the advocacy. It is about the quality of the monitoring. What are the tests and controls in terms of those stages? What are the external measures to keep monitoring those as we go along.

Q103 Baroness Finlay of Llandaff: There has been expressed a concern that we really have two categories of suicide now within this Bill. We have suicide prevention policies and we have suicide that should be facilitated through this process to have an assisted death.

I just wonder whether you could look at the scenario of the doctor who has the patient in front of them, who looks as if they are likely, possibly, to die within about six months or so and who is expressing suicidal ideation. How should that doctor be behaving? Should they be taking them down the route to an assisted death or should they be viewing that as a need for suicide prevention? That is a real scenario that, as a doctor working in palliative medicine for many years, I have come across on many an occasion.

I just wonder what your response is to that and how you feel that fits with that model that Cicely Saunders developed of the emotional and psychosocial impact on people's experience of pain and distress, which makes it all worse and increases their distress.

Dr Sarah Hughes: Certainly, from a mental health perspective, currently we would hope that the individual would take a suicide prevention approach. In fact, that is the entire way we as mental health professionals have been trained and geared to think about anybody in that situation.

I want to share a personal reflection too. My father died of cancer in 2012. He went into that situation with a very serious mental health condition. He already had it. He had had it for a very, very long time. He died a month after being diagnosed, so he would not have been able to take the benefit of this Bill. However, what was really interesting for us

as a family to observe at the time is that he had no mental health support and no emotional support during those last few months. Therefore, we know that, if he had been asked the question, "Would you like to be assisted to go now?" he would probably have said yes, but that was because he did not have all the support that he needed at that moment in time.

The question, in a way, feels uncomfortable to me because those two things cannot sit together. When I think about a doctor in that position, I think about the doctor who was listening to my father in those last few moments, the Macmillan nurses and us as a family. We wanted him to live. Even in those circumstances, I do not think it is really very easy to make a decision that is beyond suicide prevention, really.

Baroness Finlay of Llandaff: How often do you find overall, from the groups that you have looked at, that doctors are good at picking up coercive control and other forms of abuse that go on? Do you find that other people may even be better at picking it up?

Professor Jane Monckton-Smith: I will talk about general practitioners. The research says they are not great. I think there are some great ones out there—absolutely there are—but I do not think it is consistent. That would be my answer.

Cherryl Henry-Leach: I would echo that. Just over half of the interpersonal homicide reports in 2016 indicated that GPs missed opportunities to ask about the prevalence of domestic abuse in a relationship when presented with clinical concerns around a patient's presentation.

Having led a number of statutory reviews, I note again that GPs are working in an environment where the system just does not enable them to undertake that level of analysis or assessment. That needs to be done in partnership with a trained domestic abuse specialist such as a health IDVA.

Baroness Finlay of Llandaff: One of the issues in the Bill is about the co-ordinating doctor and the independent doctor. I wonder whether you have a concern that, even with training, they will not be reliably able to pick up coercive control or domestic abuse of any sort, particularly if they have not done a home visit. Professor Monckton-Smith, from the research, what are your views?

Professor Jane Monckton-Smith: Sometimes it is very, very difficult, especially if the victim does not disclose to you or does not share with you. Do you have that kind of relationship? That is not really what is happening in GP practices at the moment.

If we are going to look at only one sort of professional, that is not going to be particularly helpful. I think about it almost in terms of a Clare's law disclosure. At the point that somebody says, "I am not being coerced",

you go off and you do your Clare's law disclosure just to corroborate that. At the moment, it feels like that is not being corroborated.

Baroness Finlay of Llandaff: It has been suggested that police and local authority records should be available routinely as possible pointers to flags, even if somebody is denying. I just wonder how you feel about that.

Dr Sarah Hughes: That seems incredibly sensible. Of course, I am concerned particularly about the pressure on doctors to be able to hold all this in mind. We are also asking them to look out for sexual exploitation. We are asking them to identify vulnerability.

We hear a lot from doctors, schoolteachers and people who are responsible for vulnerable children, young people and adults about the competing pressures in relation to training to be able to spot X, Y and Z. We need to hold these practitioners in mind when we think about the range of things they have to do.

The Chair: I am going to move on, if you will forgive me.

Q104 **Lord Winston:** Can I just say that we are really impressed by the way you have conducted the issue in front of us? I feel very humble about this. I feel, interestingly, that you show the right sort of uncertainty so often about so many of the questions we are asking you. I congratulate you for this.

We are in a difficult position because, of course, you can continue to do this, but we, as parliamentarians, have to try to understand what is the most compassionate thing we can do, given what we have to do, if there is a possibility of really alleviating great suffering when really there is no alternative.

I am reminded of when I was a medical student back in the early 1960s. One of the things that we learned and was really explained to us by our teachers was a saying of William Osler's who said, "You shall not kill, but neither should you strive officiously to keep alive". That is something that I think is actually embedded in much medical thinking, for the best. I say this to you at the start because I do not think there are easy answers to any of these questions.

I want to come back to one issue, which Lord Markham pointed out earlier in his question to you. I think it is a really important question. For reasons that I do not understand, it is not clear to me that the excuses given are sufficient. We are expected to ignore the evidence that is coming from, in particular, Australia. The reason I say that is that there are five different sovereignties that have had this law working for some years apparently with very great success, which they have needed to alter from time to time with subsequent issues in Parliament.

I was listening to your story that you gave us, which is terrible, Dr Hughes. I remember my own father dying and those sorts of situations. I have to say this. Do you not think that it would be remiss of us not to

take the very best evidence that we could possibly find, which would be from sovereignties that are actually working at this, where there has been considerable public acceptance in all the states where it is working in slightly different ways? What would you say about that, Dr Hughes?

Dr Sarah Hughes: Absolutely, we must seek the best evidence globally. Where it is working well, we must draw down all the best knowledge.

For me, I am not persuaded yet that the evidence can be overlaid to a UK context. That is the bit that I am yet to truly understand and to feel convinced by and comfortable with.

There are many contextual factors that are different about us and the other jurisdictions. There are differences in terms of the way people are trained, culturally, the demographics of our communities and so on. It is not a helicopter-in scenario.

However, as somebody who really finds that all decisions should be evidence-based, of course, we need to take that evidence on board. The problem with doing that with international evidence is that sometimes—I am not saying this is always the case—we forget that the contextual overlay does not always work.

Lord Winston: If I might just turn to you for a second, Jane Monckton-Smith, I went into hospital about six weeks ago and had some surgery. I had badly broken my leg. I am in my mid-80s. I was asked at the start, before I signed my consent form, whether I wanted to be resuscitated if necessary. That seems to be a regular question. What would you say about that?

Professor Jane Monckton-Smith: It is a very difficult question that you have put there. We accept that people can say, “Do not resuscitate me”. Somebody who might be entering the processes of this Bill would have that right as well. We would not be taking that away from them, whether this Bill existed or not. I am guessing that you are asking me a philosophical question.

Lord Winston: I think I am asking you what I would regard as a fairly practical question, actually, in terms of the conduct of medicine in National Health Service hospitals under NHS treatment.

Professor Jane Monckton-Smith: This process will not be taking away people’s right.

Lord Winston: I agree.

Professor Jane Monckton-Smith: I suppose I am just wondering what the specific question was.

Dr Sarah Hughes: There are horror stories about that question and what happens. We know from the Covid inquiry, for instance, that “do not resuscitate” agreements, et cetera, were incredibly controversial. They are incredibly controversial for people with learning disabilities, mental

health, et cetera. While it is a given practice, it is still probably not entirely as safe as we would like it to be either.

Lord Winston: You say it is incredibly controversial. I would rather say it is unbelievably controversial.

Dr Sarah Hughes: Yes, agreed.

The Chair: Let us move on.

Lord Winston: Why are we not worried about that much more?

The Chair: Lord Winston, I think we should move on.

Q105 **Baroness Berger:** I will turn to you, Dr Hughes. Thank you all for being with us today and for the very powerful testimony that you are sharing with us. You have alluded to this, Dr Hughes, but can I ask you to expand? This Bill, obviously, is not happening in a vacuum. As the chief executive of the country's leading mental health charity, it would be really helpful to hear Mind's assessment of the current environment for the people you represent, specifically in the context of mental health treatment. How accessible is mental health treatment and support? Do you believe that this is a safe and/or appropriate context to introduce the Bill?

Dr Sarah Hughes: Thank you for asking the question. It is important to acknowledge that we have just released our *Big Mental Health Report*, which very much cites where we think the state of the nation is in terms of our mental health.

We are in clear decline. We are in clear decline not only in terms of the services that we are able to provide. We are also seeing a huge increase in the prevalence of all ages in terms of mental health challenges. We have near enough 2 million people on the waiting list for support. We have a number of services, across public services and the third sector, talking about the demand increasing day by day and being unable to provide services that really meet that need.

If we thinking about a safe context for this type of legislation, I would have to be really clear: it feels really uncomfortable for me to think about us considering assisted dying when we are not providing the services that people need. In mental health, if you are dying of cancer, often we know that people are making that decision about assisted dying because of that experience of being a burden.

Again, for people with mental health problems, that is a perpetual experience. Bearing in mind those factors, it does not feel safe to me within the current context. In many respects, if we could all go to sleep at night knowing that people were getting the services that they need for whatever health condition they had, then I would absolutely, wholeheartedly support this principle.

Baroness Berger: Can I ask you specifically to expand on a point that

you made in your written statement about inequalities and discrimination? Can you share with us what your concerns are relating to the Bill in that regard, specifically for people with mental health conditions?

Dr Sarah Hughes: Again, we know that, for many people who are using and accessing mental health services, their mental health challenges are a result of environmental factors including poverty, pressure in school and all sorts of things. We know that it is aggravated by external factors. Mind's position around inequality is really clear. We see, time and time again, public policy and legislation being applied in a way that disadvantages the most vulnerable.

Again, I come back to racism. I come back to those people who are living in poverty, people who are on the margins, people who are living in domestic violence environments, et cetera. All those people, all the time, have high stakes when they bump up against statutory services, policy, legislation and decision-making. It is an incredibly dangerous interface because of the subjectivity, the lack of training quality, measured outcomes and so on and so forth. There is so much within the system that can be gamed, which is worrying.

Baroness Berger: I have a separate question, if I may, to all members of the panel. It is specifically around the issue of appeal. Currently, the processes outlined in the Bill allow for an appeal if the panel says no, but there is no opportunity to appeal the decision of the panel when it says yes.

I am particularly considering that in the context of coercion. If the panel says yes, but family members, carers or wider friends have not been consulted and they have concerns about coercion, there is no opportunity for them to appeal it. What are your thoughts about that and is that something you are concerned about?

Cherryl Henry-Leach: For us, that demonstrates the importance of having an assessment that is undertaken across a span of disciplines at an earlier stage in the process, so that the panel can be comfortable and confident that coercion has been ruled out when making its decisions.

Professor Jane Monckton-Smith: I absolutely agree with my colleague. If those questions had been asked earlier, perhaps the panel might have reached a different decision, if family members were feeling that strongly that they would want to appeal.

Dr Sarah Hughes: We already know, from the work that we did around the Mental Health Act, that the role of family, again, is incredibly controversial in terms of that question of coercion. Again, there would have to be built-in safeguards around that process.

Q106 **Baroness Berridge:** Thank you so much for coming to give evidence to us today. You have mentioned a lot about coercion. It is important to note that the Home Office has had to issue a 91-page statutory guidance document to help everybody try to understand that, in addition to the

training.

My question to you is about the inclusion in the Bill of safeguards to ensure that someone has not been pressured. In those sections of the Bill, it references pressure by a person. I just wanted to put to you two other contexts. Should it include pressure by an institution? I am thinking of somebody who is terminally ill and is on a mental health ward. They are not always moved out swiftly to a hospital environment or they might be treated in that environment. There might be pressure from within that kind of institution.

I would also be interested to know your view on the interface now—if that is the right word—of domestic abuse and social media, the internet, TikTok and all of that. Pressure can come in to people and maybe perpetrators have additional tools now to use. How would you define pressure? Would you include institutional pressure? How do you view pressure from your experience with people who are domestic abuse victims in relation to other means, which are not human interfaces?

Cherryl Henry-Leach: When I think about pressure, I also am mindful of a pattern of coercive control that can be insidious and subversive. Pressure can be a tactic by a perpetrator to enforce a regime of coercive control. That is very complex and I get that, but it is important to be mindful that pressure can be a tool that indicates a pattern of coercive control.

I also agree that there does need to be caution about institutional pressures. I am particularly concerned that we are asking health professionals to make decisions in a very short period of time, with a backdrop and wider context where the wider systems currently do not work or support that decision-making process. I do not have information with me today about the wider IT, Facebook, social media aspects of it, but we can certainly see if we can get something back to you after today.

Dr Sarah Hughes: We would need to think about how this works with the Online Safety Act. I really am concerned about online coercion. That is a real risk. With the newly developed AI functions and chatbots, we already know that there are cases all around the world of individuals being coerced into all sorts of different behaviours, practices and decision-making. There needs to be a quite clearly defined interface.

We need to, again, work with those social media companies. There is also an issue of misinformation around diagnosis and prognosis. All those things need to be worked through. While the Online Safety Act attends to that, it is not quite robust enough yet.

Q107 **Lord Markham:** Dr Hughes, I wanted to follow up. You said that we must seek to get the best evidence globally and I thank you for that. You told a very moving story about your father's death and expressed your feelings about that. In terms of hearing the best evidence, would it be useful for the committee to hear from people who are terminally ill themselves, so they can share their own feelings?

Dr Sarah Hughes: Absolutely, yes, and thank you again for saying that. That is critical to being able to have a proper conversation about this. One of the things I wanted to share with you today is that we, in mental health, are probably one of the only health domains that have survivors, people who have tried to take their own lives. We have the largest group of people who have gone to the brink, have come back and have then been able to say three or six months later, "I'm so glad that that did not happen".

Of course, in response to people with terminal illness, that is slightly different, because that end of life is there, although end dates can move. I know somebody who was given a terminal diagnosis seven years ago. There are all sorts of variances to that. Certainly, hearing testimony from people who have a terminal diagnosis would give us a level of richness and security in terms of understanding what those final months and moments are like.

Q108 **Lord Goodman of Wycombe:** Can I ask all of you a quick question about independent advocates? They are set out in the Bill. Their role is set out and how they are to be appointed is set out by the Secretary of State, but nothing is actually said in the Bill about who they would be. I wondered whether you consider that there are sufficient safeguards in the Bill against independent advocates being appointed who would exercise coercion or pressure.

Cherryl Henry-Leach: An independent advocate should be exactly that: independent. If there is evidence that they are leveraging pressure over the most vulnerable, I would really recommend that those rules be regulated to prevent that occurring and to ensure accountability, should it occur.

I would also suggest that the role of a health IDVA—an independent advocate—works very well in health situations and contexts, and clinical environments, to improve outcomes for the patient. My experience of an IDVA is very positive but, in the context of this Bill, I would be signposting the committee, with respect, to the recommendation that we have made around regulation.

Lord Goodman of Wycombe: That would require amendment to this clause. The other witnesses are nodding and agree with that.

Dr Sarah Hughes: We agree with that, yes.

Q109 **Baroness Hayter of Kentish Town:** The question is for Dr Hughes. If I understood right—and I think this is something you wrote—you have said that the Mental Capacity Act is not designed for decisions to end one's own life, but it is the framework we use at the moment for decisions that do lead to death. I am interested as to why you do not think it is appropriate, when it has been used a lot and has been tested in other circumstances.

Dr Sarah Hughes: There are two responses. We are very much aligned with the assessment by the Royal College of Psychiatrists of the Mental Capacity Act's ability to provide safeguards in this situation. We also

know that the Mental Capacity Act already has quite a lot of criticism of its effectiveness. Certainly, in mental health terms, we know that there is often controversy. Where can it be applied? Who can it be applied to?

Even within its current framework, it does not provide the safeguards that we would like to see for the most vulnerable people. To apply it in this context, without any kind of test or modelling in the way that we would like to see, feels problematic.

Baroness Hayter of Kentish Town: That is a problem with the Act at the moment. You would not want two different Acts. You really want an improvement in the existing one. You would not want two to run side by side, I assume.

Dr Sarah Hughes: In terms of the technicality, no, I suppose we would not want to see two separate Acts, but this current one does not feel like it can be overlaid.

Cherryl Henry-Leach: To add to that, when we think of mental capacity in a domestic abuse situation, the difficulty is the lack of insight into the impact of coercive control on somebody's ability to make decisions, even though that has been enshrined in case law. We would support a review of the Mental Capacity Act to reflect that.

The Chair: I must now bring this session to an end. Thank you all very much indeed for coming and for the evidence you have given, which has been extremely valuable on a very important and difficult subject. I remind you that the transcript will be available. Please do take a moment to look through it and check that what you said has been correctly recorded. Let us know if there are any errors. Thank you, all three of you, very much indeed. I bring this session to an end.