HOUSE OF LORDS

Terminally Ill Adults (End of Life) Bill- Committee Stage

Opposition to this bill and principle of assisted suicide is growing and the public call Peers to protect the most vulnerable in society

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Contents

Evangelical Alliance's position on legalising assisted dying/suicide

The Evangelical Alliance UK is the largest and oldest body representing the UK's two million evangelical Christians. Established in 1846, today we work across a diverse constituency of over 27,700 individual members, thousands of churches and hundreds of organisations.

The Evangelical Alliance UK is also the founding member of the World Evangelical Alliance (World Evangelical Alliance WEA, 2025), which unites evangelical alliances based in different countries, representing over 600 million evangelical Christians worldwide. In collaboration with the WEA and The Evangelical Fellowship of Canada (The Evangelical Fellowship Canada EFC, 2025) we are able to draw on their input to multilateral discussions held at the United Nations on this issue.

On behalf of our UK members we have been engaged in assisted dying / suicide policy since 2003. Most recently submitted written evidence to Scotland's Assisted Dying for the Terminally Ill consultation, the Department of Health and Social Care's parliamentary inquiry and evidence session of this bill (Evangelical Alliance, 2025) and ongoing engagement since The Terminally Ill Adults (End of Life) Bill [hereafter referred to as 'TIAB bill'] was introduced to parliament.

Our position is underpinned by our biblical beliefs and theological convictions. We believe passionately that *human dignity* is rooted in the belief that all people are created in the image of God (Genesis 1:27). In addition, *justice and equity* are core to this issue and this bill.

Tackling health inequalities in the UK are of huge concern to the Government and the health and social care sector. Yet the elderly, disabled, women and ethnic minority communities tend to have poor outcomes which legalising assisted dying/suicide will exploit. The Health and Social Care Act 2022 sets out a national framework for palliative and end of life care which has not been implemented in full (NHS England, September 2022).

Introducing the TIAB serves as a distraction from is a national health emergency. Professor Sir Mike Richards, Chair of the Commission on Palliative Care and End of Life Care wrote in an article "the assisted dying bill has shone a spotlight on end-of-life care and the need for urgent reforms" (The Parliament Politics, May 2025). We urge Government ministers and parliamentarians to refocus attention on tackling health inequalities across society and to invest in rebuilding health and social care institutions that are accessible within communities and fit for the 21st Century.

Is it assisted dying or assisted suicide?

During the second reading in both houses some MPs and Peers alike have been horrified at the choice of words other critical of the bill have used. Using "assisted suicide" rather than assisted dying to describe this bill. However, it is important to remember that legalising assisted death amends Section 2(1) of the Suicide Act 1961; removing criminal responsibility of medical practitioners involved in informing and/or actively facilitating a person to end their own life.

> *"This is not an assisted dying Bill but an assisted suicide Bill. As a society, we believe that suicide is wrong. The Government have a national suicide prevention strategy. We bemoan the number of young people who are lured into committing suicide by social media and by what they read on the internet. This week, we had World Suicide Prevention Day. Suicide is wrong, but this Bill, in effect, says that it is okay. What message does that give to our society? Suicide is not okay. Suicide is wrong. This Bill is wrong. It should not pass."* (Baroness May of Maidenhead, Second reading in the Lords)

We agree with Baroness May. 'Assisted suicide' is a more accurate description of the policy intent and will therefore refer to this bill as legalising assisted suicide.

A matter of further concern is lack of discussion on how TIAB will impact suicide prevention funding and strategy in England and Wales. The Government's own impact assessment does not provide information on the financial impact to charities involved in support and individual's suffering from suicidal ideation or poor mental health. We unpack this point in 3.8 onwards.

Peers are being asked to vote through a bill where crucial details remain unknown

> *"There isn't a budget for this. Politics is about prioritising. It is a daily series of choices and trade-offs. I fear we've made the wrong one."* (Secretary of State for Health and Social Care, June 2025)

Worryingly the bill has progressed through the House of Commons with weaker safeguards than first promised at second reading back in November 2024. The promise of a High Court judge has been watered down to a review panel where parliamentarians and others have questioned whether this is operationally viable or possible.

In addition, key aspects of how an assisted suicide service will be delivered, operated and regulated remain unknown, especially as proponents of the bill seek to embed this within the NHS. **It is speculated that core funding for health and social care treatment and services will be redirected, restricted or even withdrawn to fully fund assisted suicide services in England and Wales.**

Below is a selection of clauses where operational decisions are determined by the Government and/or minister rather than scrutinised and voted on by parliamentarians:

- **Clauses 9, 10 and 11** through regulations, sets out what forms of ID, details on first declaration form proof of eligibility are needed for an assisted suicide.

- **Clause 22** states the secretary of state is responsible for scoping out the independent advocate roles for patients. On first reading this sounds positive but it is important to remember the bill makes no provisions for the next of kin to be informed. Currently it is possible a death could take place, and the

family find out after the fact. Megan Royal, a young women from Ireland, was informed via WhatsApp message that her mother died by assisted suicide in Switzerland (Christian Daily International, August 2025). This was deeply painful for the family, and the bill makes zero provision for families to be informed of any assisted suicide referral /decision

- Clause 27, 37 and 39 states the secretary of state will make regulation on approved substances – its prescription, storing, handling and disposing. The assumption is that assisted suicide drugs lead to pain free death. This is not always the case and research in other jurisdiction's raise concerns.

  Palliative care specialists from Australia recently wrote in the BMJ journal outlining ethical concerns. One of its findings states 'the occurrence of acute pulmonary oedema (APO) in settings such as voluntary assisted suicide has not been studied but could be potentially concerning due to the *symptoms of respiratory distress and suffocation* from APO, which a high enough dose of barbiturate, might externally mask from the external observer. The individual would be unable to move a muscle to show any signs of distress and may even look peaceful' (BMJ Forum, March 2025).

  Assisted suicide drugs are not medicine. They are designed to exceed ethical limits and to bring about death. The effects of such drugs are unknown and under-researched. This issue has still not been fully explored by either House. We were encouraged this point was raised during recent evidence session and urge Peers to limit how much can be determined in statutory instruments.

- Clause 40 and 42 sets out how the secretary of state and the Welsh minister will establish "voluntary assisted dying service" in respective nations. At the time of the vote MPs and Peers will not know if the provision is administered within the NHS, private services or a newly established service with a profit making aspect to delivery.

- Clause 47 section four calls upon the secretary of state to provide an assessment on state of health services to persons with palliative and end of life care needs at the point of implementation rather than to prior to it. This ignores that for many terminally ill patients currently inadequate access to high quality specialist palliative care means they may choose an assisted suicide pathway because of lack of choice. Access to such palliative care services is dependent on where one live and their ability to pay for private care. The Government's Equality Impact Assessment recognises that 'regional variation in palliative care could be a reason some patients to consider assisted dying **where they may not have done so if appropriate palliative care was available**' (Equality Impact Assessment, June 2025 – **our emphasis**)

- **Clause 54** empowers the secretary of state to make further provisions following the passing of the act **without** parliamentary oversight, scrutiny or foreknowledge.

In a recent poll cited in *The Independent* the public (n = 2071 and 70%) took the view that 'Peers have every right to vote against non-Government legislation if they consider that it poses a significant risk to vulnerable lives' (The Independent, September 2025). The public expects the Lords' to thoroughly scrutinise the principle and implications of this bill. It's passing in the Commons should not be interpreted as the wishes of the public. None of the political parties campaigned at the last election to legalise assisted suicide nor did the Government make a manifesto commitment to legalise assisted suicide. Instead the Government committed itself to deep reforms of both the health and social care sector, seeking 'deliver consistent service', ' rights of those in residential care to be able to see their families', 'tackle inequalities' and establish local provision that 'supports people to live independently for as long as possible'(Labour Party Manifesto, June 2024). **TIAB is a private members bill that will compromise improving healthcare for all. Peers can and must overturn a poorly written bill with negative impact in practice. There is a precent for this.**

Several clauses remain of deep concern to our membership who led hospice provisions, family support services and/or are health practitioners

Many of our member churches, charities and medical practitioners wrote to their MP or local council leader to express deep concern legalising assisted suicide would have on the vulnerable – specifically the elderly, disabled, women and/or minority ethnic communities where access to care in the community is difficult. For many they foresee these groups choosing assisted suicide as an escape from being alone or a burden to loved ones; particularly where they are dependent on social care or living in supported accommodation or a care home.

> *"Elderly people, who are in all other jurisdictions the main recipients of assisted dying, are often dependent on those who care for them (see reference 34), putting them at increased risk of elder abuse, although we have no data on this in the context of assisted dying. Pre-pandemic data (2018) from the Crime Survey for England and Wales estimates 210,000 adults between 60 and 74 years experienced domestic abuse."* (Equality and Impact Assessment, June 2025)

Faith in Later Life is one of our 522 member organisations. They exist to mobilise local church champions (circa 450 churches) to support and respond to loneliness and isolation amongst the over 65s. As part of coalition of charitable organisations and medical experts they contributed to the APPG for Longevity's report "Loneliness in Older People: guidance on how Christian faith organisations can support older people facing loneliness" in 2021. In their chapter in the report they mentioned how the "Daily Hope" helpline received over 500, 000 calls and serves as core service for the elderly during the pandemic and since "helped with sleep, chair exercises whilst on the phone and provide spiritual support for those who couldn't participate in online church." (APPG Longevity, 2021). **Loneliness is an issue for over 65s and this bill will exploit those vulnerabilities.**

The following clauses remain of deep concern to our members and the different groups they support towards the end of life. They will be the focus of our parliamentary engagement in the Lords as the bill proceeds through the House.

1. Clause 3 (Capacity)

In this Act, references to a person having capacity are to be read in accordance with the Mental Capacity Act 2005.

1.1 The Mental Capacity Act (MCA) 2005 when passed in 2007 was a landmark piece of legislation that empowered patients to make decisions on their treatment and care. Assisted suicide must not be considered a viable treatment or decision of care alongside established medical practice. Through legal and medical advice received we have reason to believe how MCA 2005 is being used in clause 3 is a misrepresentation of its original policy objectives and how it is to work in practice.

1.2 Firstly, capacity is not a binary or static decision. It is possible that a patient can determine care decision in one instance, this could change in another moment due to deterioration of their physical or mental health or wider relational concerns. The TIAB bill fails to take account of this.

1.3 NHS guidance encourages health practitioners to 'consult others' and to defer to the wishes of "assigned trusted person" (NHS, January 2024). This is in contrast with the TIAB bill where discussion of engagement with family and loved ones is limited. In reality, it is possible that a patient could make a first and second declaration, or find an individual to sign by proxy (Clause 21) before a loved one is informed or aware of the decision to hasten natural death.

1.4 TIAB bill currently written does not address manipulation or coercion of the elderly nor provides adequate safeguards to protect them from a wrongful death. Of all groups mentioned in this briefing the assisted suicide bill will disproportionately impact those aged 65 and over. In 2023, there were 581,363 registered deaths in England and Wales. 69% of which were people aged 75 years and more. (Office for National Statistics, October 2024).

1.5 The British Geriatrics Society (*BGS)* have worked on the frontline and providing medical intervention and care for the elderly for over 78 years. It is this insight that has led to them opposed to legalising assisted suicide in the UK. In their written evidence to the Commons' committee they explain there is a failure in the bill to detect coercion amongst the elderly influencing a decision for an assisted death, weak definitions in the bill and an acceptance that 'being a burden' to family or caring institution is a legitimate reason to request and pursue an assisted death (Parliament, February 2025).

1.6 In additions to vulnerabilities to the elderly, the TIAB bill does not engage with disproportionate impact to those from a minority ethnic background and their challenges to access services and even palliative care provision. Dr Jamilla Hussain a palliative care specialist gave evidence during Commons select committee and spoke about possibility

legalising assisted suicide will deepen mistrust in the medical advice practitioners give and risk patients avoiding treatment, assessment or appointments because of fear (Parliament TV, March 2025).

1.7 Proponents of this bill tend to equate choice with how the MCA 2005 defines capacity; blurring language in this way is unhelpful in what is understood amongst medical practitioners, the law and general public. Regardless of one's socio-economic status or protected characteristic the MCA protects individuals to make clinical decisions, but those decisions are taking in the round of one's personal circumstances. Many of the vulnerable groups we cite above do not have genuine choice in the care they desire because of lack of information, mistrust in institutions or practitioners or based on where they live.

1.8 We would urge Peers to introduce amendments on palliative care assessment at the point of determining eligibility **and** also to push amendment to clause 47 where palliative care for terminally ill patients. See 1.9 for rationale.

1.9 The Equality and Human Rights Commissioner spokesperson at the committee said as part of their opening address: *"It would significantly mitigate the risks of discriminations that might arise from this bill and improve compliance with human rights if an assessment of health and social care, and especially palliative care for terminally ill people were conducted* ***before the legislation comes into force note as part of its implementation as clause 47 currently provides.****"* (House of Lord's oral evidence, October 2025 – **our emphasis**)

2 Clause 5 (Preliminary discussions registered medical practitioners)

2.1 Nurses, GPs, palliative care consultants and those from the wider medical field are the access point to health and social care service for the general public. Their priority should be in the assisting of care, providing pain relief treatment and diagnosing of sickness and provision of treatment to preserve and prolong life. Not to "discuss" or "exercise their professional judgement" to quicken assisted suicide pathway for patients as cited in clause 5. A concern raised by family members and individuals with long-term sickness is how assisted suicide undermines patient and practitioner relationship if legalised.

2.2 The Equality and Impact Assessment acknowledged that disabled people are 'more susceptible to feeling as though they are a burden on those around them' yet does not seek to mitigate the indirect or direct psychological pressure disabled people would face from individuals or even health practitioners. Point 3.1 reminds Peers of the prejudices and negative differential treatment disable people face by health practitioners (Equality and impact assessment, June 2025).

2.3 The assessment also recognises that disabled individuals are 'twice as likely to be victims of domestic abuse compared to non-disabled people'. These pressures are not always overt and cannot be reliably identified through formal declarations. (Domestic Abuse Act-Statutory Guidance, 2022).

2.4 Women statistically carry most of the caring [paid and unpaid] for family members and the public in the UK. TIAB bill will have a direct and indirect impact on this cohort's social, physical and psychological wellbeing if legalised. According to the Lord Darzi independent review into the state of health and social care in Britain, it states, "Nearly 60 percent of carers are women, and the largest group are in their later 50s. There are more very elderly carers, including 6.3 per cent of women aged over 85 and 2.9 per cent of women aged over 90" (Professor Lord Dazi of Denham, September 2024).

2.5 Christan leaders and churches played a crucial role during the COVID-19 pandemic and are acutely aware of the barriers to accessing health and mistrust felt amongst diaspora communities when it comes to the medical profession. Introducing assisted suicide risks entrenching those fears further. See paragraph 2.6, an extract from *The Association for Palliative Medicine's Race Equity Committee* submission to the public bill committee.

2.6 "*Mistrust in end-of-life care is a significant issue, with many communities already reluctant to engage in palliative care services due to the perception, for example, that hospices exist to kill people. Over the past decade, significant work has been done to improve access and build trust amongst Asian and Black communities. Staff from these groups described fear that the introduction of assisted suicide would undo this work, setting efforts back significantly and creating an even wider void between these communities and good access to high quality palliative care.*" (Parliament UK, February 2025)

3 Clause 31 – 33 (Protections for health professionals and other)

3.1 The spokesperson from the National Down syndrome policy group during Lord's bill committee said: *"There is a real fear among the people with Down syndrome I have spoken to that this Bill will further target their lives. There are huge health inequalities. If I talk in particular about people with Down syndrome, they typically die 27 years earlier than their Peers. The LeDeR report, which came out this year, showed that 37% of deaths among people with a learning disability were from preventable causes."* (House of Lords oral evidence, October 2025)

3.2 Along with social justice charity organisations, our members who run care services or co-fund end of life provision locally are concerned how the introducing of assisted suicide impacts vulnerable groups in society. Ahead of the second reading we mobilised over 1200 Christian leaders to sign a joint letter in opposition to assisted suicide. These are church leaders that have walked closely with families through the death of a loved one, or community leaders that have run outreach projects where they have witnessed a correlation between poverty and health inequalities or others who directly fund or support the running of hospice care in the community. (Evangelical Alliance, November 2024).

3.3 Given the strength of opposition from disability groups, hospice and/or care providers to assisted suicide it would be reasonable for conscience clauses to extend to institutions and organisations as well as individuals. An institutional opt-out clause was proposed at the Commons committee stage and again by Labour MP for Vauxhall Florence Eshalomi during report stage but was voted against.

3.4 Clause 31 applies only to individuals and not institutions, despite proposed amendments during report stage amendment to recognise palliative and end of life care hesitancy to facilitate and/or administer assisted suicide on their premises. Palliative care nurses and specialists within our membership along with those who gave evidence to the Commons and Peers select committee have expressed hesitation to facilitating assisted suicide of a patient.

3.5 Our counterparts in Canada have made us aware of legal cases that evidence institutions refusing to participate have seen a reduction in funding. In February 2021, the public health authority in British Columbia Canada stopped circa $1.5 million funding to *Delta Hospice Society* for "refusing to provide Medical Assistance in Dying on its premises. The hospice later closed (British Columbia, February 2020).

3.6 The inclusion of an institutional conscience objection clause [alongside protections for practitioners] was raised by Baroness Keeley's amendment to Clause 31 for hospices, Baroness Fraser's amendment for third-part businesses and Baroness Grey-Thompson's amendment for organisations. A series of amendments tabled by Baroness O'Loan to Clause 31 also seek to provide for a comprehensive conscience protection, allowing any person to opt out of any activity, not just medical practitioners.

3.7 During committee stage, we urge Peers to speak to this concern and seek amendments that guarantee third sector access to funding will not be redirected to facilitate an assisted suicide pathway in health and social care.

3.8 Clauses 31 and 32 refer specifically to how the Suicide 1961 Act will be amended. To date, parliament have yet to explore how compatible an assisted suicide service is with a government's suicide prevention strategy, especially as TIAB is proposed to be free at the point of need. Nor have parliamentarians explored the cultural and societal implications of normalising death through VAD service. Peers during committee must explore the funding and operational impact to other suicide prevention charities and we would be happy to propose amendments if of interest.

3.9 Finally, during oral evidence in the House of Lords Mr Thomas Teague former Chief Coroner queried deaths by assisted suicide not being referred to the coroner for investigation which is current practice for all suicides in England and Wales (Clause 38 amends the Coroners and Justice Act 2009). This means in practice assisted suicide deaths that occur as a result of coercion would not be investigated.

3.10 *HHJ Thomas Teague KC said in committee "My concern is that the proposed removal of what are called assisted deaths from the category of unnatural deaths would do nothing to address the real risks that are liable to accompany those deaths, risks which the Bill recognises in its long title by accepting that there have to be safeguards. Indeed, the risk, in my view, is that re-categorising assisted deaths—which are, in reality, deaths by suicide—as natural deaths may have the unfortunate and unintended consequence of tending to obscure and conceal those risks, making it easier for persons who want, for example, to exercise coercion, pressure or deception, to do so.* (House of Lords Oral evidence, October 2025).

4 Clause 34 (Dishonesty, coercion or pressure)

4.1 Proponents of this bill and the principle of assisted suicide believe clauses around training for coercive control are sufficient to protect wrongful deaths. They are not and the Government's own impact assessments attest to this (See paragraph 123 of the Government Impact Assessment, July 2025).

4.2 The Equality Assessment acknowledges that healthcare professionals often lack sufficient training or willingness to engage in conversations about domestic abuse and may be 'unwilling to engage in conversations.' This presents a serious flaw in the safeguards proposed by the Bill. Doctors responsible for assessing voluntariness may not have the skills or time to recognise abuse-related coercion — leaving women vulnerable to making decisions under duress. (Commons Library, 2021).

4.3 The Impact Assessment highlights the Equality and Human Rights Commission's findings that coercion or pressure may not only be applied directly via other individuals. There is no effective mechanism in the Bill to detect and prevent this subtle elder abuse. The Commission also warns that older people 'may feel subtly pressured to end their lives prematurely'—a risk the Bill fails to eliminate. (Equality and Human Rights Commission, November 2024)

4.4 Baroness Ritchie's amendment to clause 1 clarifies that coercion or pressure would not need to come from another person. For example, it could be from an institution or arise from a set of circumstances. We are urging Peers to support this amendment.

4.5 We also urge Peers to give special attention to the contribution made by Caroline Abrahams, Director of Age UK given as part of the Lord's select committee sessions in addition to what we set out below. She referenced the challenge of detecting coercion by domestic abuse, stating: *"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."* (House of Lords oral evidence, October 2025)

4.6 The vulnerable, particularly women, remain at risk should this bill become law due to inadequate safeguards detecting coercion and control at the point of request and throughout the process.

4.7 Several female colleagues from the Evangelical Alliance along with 100 other female faith leaders signed an open letter expressing deep concern in the bills lack of cultural and religious awareness of women of faith's experience to partner violence and the barriers to support or justice. (Theos, April 2025).

4.8 Evidence shows women in domestic abusive relations are committing suicide. Between April 2023 and end of March 2024, there were 98 suspected victim suicide following domestic abuse (SVSDA) in England and Wales (Guardian, March 2025). The bill does not engage with this reality nor are its coercive control training for the assisted dying review

panel or doctors a guarantee to detecting all such cases of abuse. Detailed amendments were proposed during committee, rejected and must be sought again.

4.9 Alarmingly, deaths by suicide after domestic abuse are not always investigated as potential homicide and the extended families have had to fight for justice and truth of domestic homicide review to engage in the case (Guardian, October 2025).

4.10 The TIAB bill's ability to detect coercion is not thorough enough. It amends the 1961 Suicide Act to fundamentally change how criminal prosecution is structured. The categories of "dishonesty, coercion or pressure" are already too complex to determine cases of domestic abuse (Government's Impact Assessment, 2025 – paragraph 377). The TIAB bill as currently written enables situations where a woman in abusive relationship could access an easily access an assisted suicide pathway as means of escape.

4.11 The TIAB bill leaves it to regulations to determine the length of time and content for mandatory training for practitioners to assess domestic abuse, coercive control or financial abuse. This should not be determined in regulations but made clear on the face of the bill where parliamentarians can vote on.

To conclude, introducing an assisted suicide service in England and Wales will endanger the lives of those living in poverty or with chronic health needs already struggling to access treatment and care in the communities where they live.

Health inequalities prevalent within NHS and an assisted suicide will entrench such inequalities further. The decision before Parliament is clear, to proceed with this bill or to reject it and redirect efforts to give individuals the best outcome as they near the end of life, the option to die with loved ones, secure in a strong and effective palliative care system.

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