1. **Introduction**
   1. The Equality Impact Assessment for the Terminally Ill Adults (End of Life) bill was published alongside the impact assessment on 2 May 2025.
   2. For a bill that proposes such fundamental changes to the practice of medicine in England and Wales, this was inexcusably late on in its passage through Parliament.
   3. Due regard for equalities impacts should occur at the beginning of any new initiative and inform the development of that initiative. An EqIA should not be treated as a bolt on extra.
   4. We have significant concerns about the content of this EqIA and agree with commentators who have raised concerns about its adequacy.[[1]](#footnote-1)
   5. It takes at face value safeguards contained within the bill despite concerns raised by numerous professional bodies, organisations and individual witnesses as to their lack of strength.
   6. It also misses a number of potentially significant adverse equalities impacts and therefore also fails to propose measures to mitigate the risk of those.
   7. A criticism of the passage of the bill shared by doctors and Deaf and Disabled People’s Organisations (DDPOs) is the lack of engagement and account taken of our respective views, informed by expert opinion and lived experience, as well as those of other marginalised groups.[[2]](#footnote-2)
   8. The EqIA is one example where our input would have been beneficial.
2. **Summary of concerns** 
   1. Lateness of publication – the EqIA was published on 2 May, more than a month after the end of Committee stage and just two weeks before the first report stage debate.
   2. Coercion - the EqIA gives an inadequate assessment of risks of coercion and the strength of safeguards contained within the bill.
   3. Capacity – the EqIA fails to note question marks regarding the appropriateness of the bill’s use of the Mental Capaity Act (MCA) as a safeguard.
   4. Lack of disability understanding – mental health is inappropriately included as a separate category distinct from disability.
   5. Adverse equalities impacts gaps and omissions – there are a number of potential adverse equalities impacts relevant to the bill that are not included within the EqIA.
   6. These include:
      1. Disability – risk due to inadequate services to live
      2. Disability – risk of medical coercion
      3. Disability – risk from failure to exclude anorexia and voluntary stopping of eating and drinking
      4. LGBTQ+ - risk from fear of accessing palliative care services due to discrimination
      5. Racialised communities – lack of awareness and lower referral levels for end of life services
      6. Socio-economic disadvantage – risk of seeking assisted dying as a response to poverty
      7. Women – risk of coercion owing to inability to continue care-giving roles within the family
      8. Intersectional impacts for Disabled people experiencing socio-economic disadvantage; members of the LGBTQ+ community living with mental distress; women experiencing socio-economic disadvantage who are therefore at higher risk of domestic abuse
      9. Wider societal impacts including risk of an increase in non-assisted suicide rates and increased levels of disability hostility and hate crime

2.7 The EqIA is unfit for purpose and increases our already significant concerns regarding the adequacy of safeguards in the bill and its potential to cause adverse equalities impacts.

1. **Lateness of publication**

3.1 The EqIA was published on 2 May which was more than a month after the conclusion of the Committee stage of the bill on 25 March 2025.

3.2 During Committee stage, a line-by-line analysis of the bill was undertaken as well as debate and voting on proposed amendments to the bill. It would have been beneficial to have had an EqIA before Committee stage, in order to inform the consideration of amendments.

3.3 The assessments were published just two weeks before the first report stage debate which took place on 16 May, with the impact assessment being 150 pages long.

3.4 Publication was a Friday which, along with the weekend, is traditionally dedicated to constituency work for MPs. This makes it unlikely that MPs would have become aware of the publication of these documents – if they did at all – until the Monday following publication, giving them in effect less than two weeks to read and digest.

**4. Key Concerns**

4.1 **COERCION**

4.1.1 The EqIA accepts that Deaf and Disabled people are at particular risk of coercion to end our lives when we do not want to die, although it fails to mention intersectional impacts placing certain groups at higher levels of risk.

4.1.2 It accepts at face value the adequacy of safeguards contained within the bill intended to mitigate risks of coercion. This is despite concerns raised by a number of specialist professional bodies and organisations such as the Royal College of Psychiatrists,[[3]](#footnote-3) domestic abuse organisations[[4]](#footnote-4) and Deaf and Disabled People’s Organisations (DDPOs).

4.1.3 The bill includes provision of training for doctors in domestic abuse including coercion. It also includes a multi-disciplinary panel whose role will be to rubber stamp applications for assisted dying.

4.1.4 Professional opinions shared with the bill Committee and the bill’s sponsor have emphasised the difficulty in detecting coercive control even by professionals with many years of experience.[[5]](#footnote-5)

4.1.5 Professional bodies have also raised concerns about the use of multi-disciplinary teams at the end of the assessment process to rubber stamp applications for assisted dying with no obligation to see the person themselves or anyone involved in their life or their support.[[6]](#footnote-6)

4.1.6 This represents a mis-use of MDTs and their respective expertise. MDTs are properly used to collectively identify solutions to overcoming challenges that individuals face in living decent lives with the support they need.

4.1.7 An appropriate place for an MDT within the application process would be at the beginning, with a focus on identifying whether changes to the person’s living arrangements and provision of additional supports and adaptations could replace the wish to die.

4.1.8 This would act as a much stronger safeguard but was rejected by the bill’s sponsor and the bill Committee.

4.2 **CAPACITY**

4.2.1 The EqIA refers to use of the Mental Capacity Act (MCA) as a safeguard for ensuring that applicants have a “clear, settled and informed” wish to die with no assessment of the relative strengths or weaknesses of this as a measure for reducing risk to groups with certain protected characteristics.

4.2.2 The MCA has a presumption of capacity and is not able to detect where a person both has capacity and has impaired judgement due to mental distress, coercion or internalised oppression.

4.2.3 The EqIA ignores evidence submitted to the Committee concerning the limitations and inappropriateness of the MCA as a test for this from, among others, DDPOs, the Royal College of Psychiatrists (RCPsych) and the Royal College of Physicians (RCP).[[7]](#footnote-7) [[8]](#footnote-8)

4.2.4 Safeguards voted down at Committee stage could have strengthened this area, for example a requirement that the independent doctor be a registered psychiatrist.[[9]](#footnote-9)

4.2.5 A lack of adequate safeguards places people experiencing depression as a response to a terminal illness diagnosis, people with pre-existing mental health conditions including suicidal ideation, Deaf and Disabled people in general and women at particular risk of being given access to assisted dying when it is not their clear, settled or informed wish to die.

4.3 **LACK OF DISABILITY UNDERSTANDING**

4.3.1 The EqIA indicates a lack of proper understanding of disability in that it includes mental health as a separate category rather than under disability. [Disability pp. 6-11; mental health pp.18-19]

4.3.2 This contravenes both social model and human rights models of disability (which are themselves aligned with each other).

4.4 **ADVERSE EQUALITIES IMPACTS GAPS AND OMISSIONS**

4.4.1 There are a number of omissions relating to potentially adverse equalities impacts on Deaf and Disabled people, women, racialised minorities and members of the LGBTQ+ community, as well as intersectional impacts and potential adverse impacts to wider society. These are listed in the section below.

4.4.2 The existence of these potential impacts has been flagged in numerous pieces of evidence that the bill Committee and sponsors were made aware of through both oral evidence and written submissions.

4.4.3 The central focus of those equalities impacts that have been included is on ensuring equal access and inclusion to the proposed assisted dying service.

4.4.4 We contend that the bigger concern should be on assessing risk to groups with protected characteristics and in this regard the EqIA is worryingly lacking.

**5 Equalities impacts gaps and omissions**

5.1 **DISABILITY**

5.1.1 **Inadequate support to live**

5.1.2 Financial hardship, inadequate social care support or housing can make a person want to die.

5.1.3 Deaf and Disabled people are at much greater risk of experiencing each of these factors either separately or at the same time.

5.1.4 In 2016, an unprecedented inquiry carried out by the United Nations Disability Committee found the UK government guilty of grave and systematic violations of Disabled people’s rights. Income, social care provision and availability of suitable housing were among the specific areas investigated in the course of the inquiry.

5.1.5 A follow up to the inquiry in 2024 found no significant progress had been made in these areas and in some there had been relapses.

5.1.6 The bill makes no provision to assess unmet needs at any stage, nor consult others involved in the person’s life or in their support.

5.1.7 A safeguard against this – to exclude from eligibility those seeking an assisted death due to feeling a burden[[10]](#footnote-10) – was voted down at Committee stage.

5.1.8 The EqIA proposes no alternative measure to mitigate the risk that Deaf and Disabled people will be exposed to through passage of this bill as a result of inadequate support to live.

5.1.7 This another reason why DDPOs, RCPsych and RCP cannot support the bill in its current form.[[11]](#footnote-11) [[12]](#footnote-12)

5.1.8 The cost savings in the health and social care budgets attributed to the bill in the impact assessment[[13]](#footnote-13) has increased concerns among Deaf and Disabled people that the bill’s central aim is to prematurely end the lives of those with high cost support needs, and that assisted dying will be used in place of investing more in palliative care as well as social care, mental health and housing.

5.1.9 By not addressing the risk posed by legalisation of the bill in combination with the current state of inadequate support provision, the EqIA encourages those fears.

5.1.10 **Medical coercion**

5.1.11 The EqIA does not mention risk of medical coercion for seeking assisted suicide.

5.1.12 This relates to a sensitive but very real issue experienced by Deaf and Disabled people. We do not currently have equal access to healthcare. Discrimination and medical negligence occur too often. In times of treatment rationing, Disabled people are de-prioritised according to official clinical guidance. This encourages a view within health service provision that our lives are of lesser value.

5.1.13 There was a public out-cry against Do Not Attempt Cardiac-Pulmonary Resuscitation (DNACPRs) used unlawfully or through coercion on the medical notes of Disabled people.[[14]](#footnote-14) This however reflects routine practice.

5.1.14 DDPOs were unsuccessful in lobbying the bill Committee to prevent doctors from being able to raise assisted dying with eligible patients. We had hoped this would mitigate the risk of medical coercion.

5.1.15 As mentioned in the EqIA, clause 20 of the bill makes provision for access to independent advocates for “qualifying persons” including “those with learning disabilities, mental disorders, autism or other ‘substantial difficulties’ in understanding processes or information”. [p.11] This is welcome but it does not cover all groups of Disabled people. All are at risk of feeling coerced. It is also unclear how the provision of independent advocates will work and how these will be resourced when there is already a shortage of available advocates.

5.1.16 **Mental Health**

5.1.17 The bill does not restrict eligibility from those experiencing life threatening physical affects as the result of mental distress, for example those with severe anorexia and those who voluntarily stop eating and drinking in order to meet eligibility criteria for the bill.[[15]](#footnote-15)

5.1.18 This group is therefore at particular risk of being given access to assisted dying when it is not their clear, settled or informed wish to die.

5.1.19 This is not mentioned within the EqIA.

5.1.20 The sponsor said on the first day of report stage debate that she will reword an amendment put forward to close this loophole and bring it back to be voted on, causing the MP moving the amendment to need to withdraw it. [[16]](#footnote-16) It is not clear how this will happen and what mechanism is available to her to do this. We await more information.

5.2 **LGBTQ+**

5.2.1 The EqIA refers to the fact that people from LGBTQ+ communities “often access palliative care and end of life care services late or not at all, due to fear of discrimination.” [p.12]

5.2.2 It goes on to stress that the voluntary assisted dying service set up by the bill will not discriminate but makes no mention of the risk this poses in terms of people who are LGBTQ+ accessing assisted dying not through a wish to die but due to either a genuine or perceived lack of appropriate alternative service provision.

5.2.3 No measures are therefore proposed to mitigate this risk.

5.3 **RACIALISED COMMUNITIES**

5.3.1 Data is available that shows how people from racialised communities are less likely to be aware of and to access palliative care services.[[17]](#footnote-17)

5.3.2 This is within a context of overall low levels of public awareness about what is and is not legal and what options exist for people with terminal conditions at risk of pain.[[18]](#footnote-18)

5.3.3 Research also shows that people from racialised communities experience lower rates of referrals to end-of-life (EoL) care services, higher levels of dissatisfaction with services, and perceive some services as culturally inappropriate.[[19]](#footnote-19)

5.3.2 People from racialised communities would therefore be at greater at risk of thinking that assisted dying was their only option.

5.3.3 None of this is mentioned and no measures are proposed to mitigate against this potential inequality impact. Instead the EqIA concentrates on explaining measures to ensure the voluntary assisted dying service is accessible to different ethnic groups and nationalities irrespective of language barriers. [p.13]

5.4 **SOCIO-ECONOMIC BACKGROUND**

5.4.1 The EqIA fails to mention that people from lower income groups are less likely to be aware of or to access palliative care services.[[20]](#footnote-20)

5.4.2 The EqIA includes mitigations such as provision of accessible information to ensure equal access to the assisted dying service. It does not provide for the provision of accessible information about alternative options.

5.4.3 The EqIA omits mention of poverty as creating a risk factor for those who have terminal conditions and are finding life unbearable not due to that terminal condition but due to living in conditions of unmet socio-economic need.

5.4.4 Deaf and Disabled people are at particular risk from this due to high rates of disability-related poverty.

5.4.5 Even before the cost-of-living crisis, disability-related poverty was found to account for more than half of all poverty in the UK.[[21]](#footnote-21) This situation will become much worse once more than 350,000 households containing a Disabled person are pushed into poverty under current government proposals.[[22]](#footnote-22)

5.5 **WOMEN**

5.5.1 The EqIA records that women disproportionately provide unpaid and end of life care [p.12] but fails to mention the greater risk of either explicit or indirect coercion that this bill poses to women arising from disparity for situations where women become unable to continue their caring responsibilities within the family due to terminal illness or a neurodegenerative conditions.

5.5.2 The EqIA references that women are more likely to be victims of domestic abuse [p.12] but fails to mentioned that women experiencing abuse are more likely to die by suicide than by homicide.[[23]](#footnote-23) This is important within the context of the bill.

5.5.3 Detecting that someone is experiencing suicidality not as the result of their terminal conditions but as the result of domestic abuse is extremely difficult to detect, according to professionals with expertise in this area.

5.5.4 The EqIA describes the role of the multi-disciplinary panel as a safeguard against coercion but, as above, the strength of this safeguard is severely limited by not having it at the very beginning of the application process.

5.6 **INTERSECTIONAL IMPACTS**

5.6.1 **People who are LGBTQ+ and have mental health conditions**

5.6.1.1 People who are LGBTQ+ are statistically more likely to live with mental distress and suicidal ideation.[[24]](#footnote-24) This is not referenced within the EqIA.

5.6.1.2 As above, the EqIA does mention that people who are LGBTQ+ are less likely to access palliative care services due to fear of discrimination.

5.6.1.3 This creates an intersectional impact with higher risk attached, yet neither this nor any specific mitigations are referenced.

5.6.2 **People from racialised communities experiencing socio-economic disadvantage**

5.6.2.1 People from racialised communities are at greater risk of poverty.[[25]](#footnote-25)

5.6.2.2 Both those from racialised communities and those who experience socio-economic disadvantage are less likely to be aware of or to access palliative care.[[26]](#footnote-26) This therefore presents an intersectional impact of heightened risk.

5.6.2.3 The bill places a duty on doctors to explain all appropriate treatment options to applicants for assisted dying. A post code lottery already operates within palliative care with services in need of funding and making cuts.

5.6.2.4 t is unclear how this duty will work when appropriate alternatives are not available in certain locations and does too little to minimise risk within the current climate.

5.6.2.5 This is not discussed within the EqIA.

5.6.3 **Women facing socio-economic disadvantage**

5.6.3.1 Women who are poor are more likely to suffer domestic abuse, they suffer domestic abuse more often and are the victims of more types of abuse.[[27]](#footnote-27)

5.6.3.2 There is therefore an intersectional impact creating enhanced risk of coercion for women facing socio-economic disadvantage.

5.6.3.3 This intersectional impact is even greater for Disabled women who are both more likely to live in poverty and to experience domestic abuse.

5.6.3.4 These intersectional risks are not considered within the EqIA.

5.7 **WIDER ADVERSE SOCIETAL IMPACTS**

5.7.1 **Suicide across the population**

5.7.1.1 Although the available evidence is limited from jurisdictions where assisted dying has been legalised for those with terminal conditions, what does exist indicates that legalisation does not reduce non-assisted suicides even among those with terminal illness.[[28]](#footnote-28)

5.7.1.2 Evidence from jurisdictions where both assisted dying and euthanasia have been legal for a number of years, such as Belgium and The Netherlands, show a higher incidence of non-assisted suicide per capita than in the United Kingdom. [[29]](#footnote-29)

5.7.1.3 One reason for this may be because legalisation normalises suicide. Suicide is known to have an endemic quality.

5.7.1.4 Within the current context of escalating levels of mental distress among the UK population, the risk of increasing non-assisted suicide rates is a potential impact of legalisation that needs to be taken into serious consideration yet is absent from the EqIA.

5.7.2 **Disability hostility and hate crime**

5.7.2.1 Both online and in person disability-motivated hostility and hate crime are an increasing problem.[[30]](#footnote-30)

5.7.2.2 Hostile comments such as that Disabled people should have been aborted at birth are unfortunately common.[[31]](#footnote-31)

5.7.2.3 Disabled people from jurisdictions where assisted dying has been legalised report the emergence of a narrative that they are selfish for not seeking an assisted suicide/euthanasia when it is available to them and that by ending their lives early, they would be removing the additional pressure on public services that they are seen to represent.[[32]](#footnote-32)

5.7.2.4 The risk of legalisation fuelling disability-related hostility and hate crime is not considered within the EqIA. Any consideration of possible mitigations is therefore also missing.

**6. Conclusion**

6.1 The EqIA is unfit for purpose and increases our already significant concerns regarding the adequacy of safeguards in the bill and its potential to cause adverse equalities impacts.

1. <https://x.com/soniasodha/status/1918341432282083670>

   <https://x.com/kesleeman/status/1918333123625947556> [↑](#footnote-ref-1)
2. <https://news.sky.com/story/its-simply-not-safe-a-thousand-doctors-write-to-mps-urging-them-to-vote-against-assisted-dying-bill-13380847> [↑](#footnote-ref-2)
3. https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2025/05/13/the-rcpsych-cannot-support-the-terminally-ill-adults-(end-of-life)-bill-for-england-and-wales-in-its-current-form [↑](#footnote-ref-3)
4. https://www.womensaid.org.uk/womens-aid-highlight-the-impact-of-the-assisted-dying-bill-on-those-experiencing-domestic-abuse/ [↑](#footnote-ref-4)
5. https://publications.parliament.uk/pa/cm5901/cmpublic/TerminallyIllAdults/memo/TIAB67.pdf [↑](#footnote-ref-5)
6. https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2025/05/13/the-rcpsych-cannot-support-the-terminally-ill-adults-(end-of-life)-bill-for-england-and-wales-in-its-current-form [↑](#footnote-ref-6)
7. <https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2025/05/13/the-rcpsych-cannot-support-the-terminally-ill-adults-(end-of-life)-bill-for-england-and-wales-in-its-current-form> [↑](#footnote-ref-7)
8. <https://www.rcp.ac.uk/policy-and-campaigns/policy-documents/rcp-position-statement-on-the-terminally-ill-adults-end-of-life-bill-9th-may-2025/> [↑](#footnote-ref-8)
9. https://publications.parliament.uk/pa/bills/cbill/59-01/0012/amend/terminally\_ill\_adults\_rm\_pbc\_0109.pdf [↑](#footnote-ref-9)
10. <https://www.telegraph.co.uk/politics/2025/01/27/feeling-burden-reason-assisted-dying-james-cleverly/> [↑](#footnote-ref-10)
11. https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2025/05/13/the-rcpsych-cannot-support-the-terminally-ill-adults-(end-of-life)-bill-for-england-and-wales-in-its-current-form [↑](#footnote-ref-11)
12. https://www.rcp.ac.uk/policy-and-campaigns/policy-documents/rcp-position-statement-on-the-terminally-ill-adults-end-of-life-bill-9th-may-2025/ [↑](#footnote-ref-12)
13. https://publications.parliament.uk/pa/bills/cbill/59-01/0212/TIABImpactAssessment.pdf [↑](#footnote-ref-13)
14. https://www.disabilityrightsuk.org/news/covid-19-inquiry-told-do-not-resuscitate-communication-people-learning-disabilities?srsltid=AfmBOooiK2N9TvxBkh7iSNTZW2ucfcoVzmEhuJ5vo2W0scibupLAdPqO [↑](#footnote-ref-14)
15. https://www.newstatesman.com/comment/2025/06/the-loophole-in-the-assisted-dying-bill-that-no-one-wants-to-talk-about [↑](#footnote-ref-15)
16. Ibid. [↑](#footnote-ref-16)
17. <https://www.kcl.ac.uk/news/65-of-adults-are-worried-about-access-to-palliative-care> [↑](#footnote-ref-17)
18. Ibid. [↑](#footnote-ref-18)
19. https://doi.org/10.1016/j.jpainsymman.2011.04.012 [↑](#footnote-ref-19)
20. <https://bmcpalliatcare.biomedcentral.com/> [↑](#footnote-ref-20)
21. <https://socialmetricscommission.org.uk/wp-content/uploads/2023/12/SMC-2023-Report-Web-Hi-Res.pdf> [↑](#footnote-ref-21)
22. <https://www.inclusionlondon.org.uk/wp-content/uploads/2025/05/Benefit-Cuts-MP-Briefing.pdf> [↑](#footnote-ref-22)
23. https://news.npcc.police.uk/releases/report-reveals-scale-of-domestic-homicide-and-suicides-by-victims-of-domestic-abuse [↑](#footnote-ref-23)
24. https://www.rethink.org/advice-and-information/living-with-mental-illness/lgbtplus-mental-health/lgbtplus-mental-health/ [↑](#footnote-ref-24)
25. <https://irr.org.uk/research/statistics/poverty/> [↑](#footnote-ref-25)
26. https://media.sueryder.org/documents/Inequity-in-palliative-andend-of-life-care-and-bereavement-support-an-umbrella-review.pdf [↑](#footnote-ref-26)
27. <https://new.basw.co.uk/sites/default/files/2024-01/181317%20Poverty%2C%20Social%20Inequality%20%26%20Domestic%20Abuse.pdf> [↑](#footnote-ref-27)
28. <https://doi.org/10.1192/bjo.2022.71> [↑](#footnote-ref-28)
29. <https://en.wikipedia.org/wiki/List_of_countries_by_suicide_rate> [↑](#footnote-ref-29)
30. <https://www.theguardian.com/society/2019/may/10/online-hate-against-disabled-people-rises-by-a-third> [↑](#footnote-ref-30)
31. <https://publications.parliament.uk/pa/cm201719/cmselect/cmpetitions/759/75905.htm> [↑](#footnote-ref-31)
32. <https://www.dailymail.co.uk/health/article-13625001/disabled-woman-euthanasia-Canada-nurse-suicide.html> [↑](#footnote-ref-32)