

[REDACTED]
National Medical Director
Skipton House
80 London Road
SE1 6LH

Mr Alan Craze, HM Senior Coroner East
Sussex)
Coroner's Office (East Sussex)
Unit 56
Innovation Centre
Highfield Drive
St Leonards on Sea
East Sussex
TN38 9UH

18th June 2021

[REDACTED]
[REDACTED]
Dear Mr Craze,

Re: Regulation 28 Report to Prevent Future Deaths – Jennifer Sarah Myfanwy Spencer (16 November 2019)

Thank you for your Regulation 28 Report dated 13 January 2021 concerning the death of Jennifer Sarah Myfanwy Spencer on 16 November 2020. Firstly, I would like to express my deep condolences to Jennifer's family. My apologies for the delay in responding.

The regulation 28 report concludes Jennifer's death was a result of multiple injuries and death by suicide.

Following the inquest, you raised concerns in your Regulation 28 Report to NHS England regarding a lack of awareness amongst Mental Health professionals about 'Shamanic' hallucinogenic drugs and their propensity to cause or exacerbate psychosis, resulting in sub-optimal treatment and care. In this response I will set out the steps we are taking in NHS England/ Improvement to address the issues outlined in your report.

Reducing suicide and preventing self-harm is a key priority for NHS England/ Improvement. We are working closely with partners, including Public Health England and the Department of Health and Social Care to support local areas to deliver multi-agency suicide prevention plans. As part of the £2.3billion settlement for mental health in the [Long Term Plan](#), we are providing targeted and ring-fenced funding to all Sustainability and Transformation Partnerships (STPs) so they can deliver their multi-agency plans. This includes suicide prevention activities, initiatives to prevent self-harm and putting in place postvention bereavement support. By 2023/24, this will total £57M additional investment in suicide prevention and bereavement.

To support these STPs, there is a bespoke national suicide reduction support

NHS England and NHS Improvement



package with the [National Confidential Inquiry into Suicide and Safety in Mental Health](#) (NCISH) and [National Collaborating Centre for Mental Health](#) (NCCMH) working together to support STPs in their quality improvement plans, as part of the national suicide prevention programme.

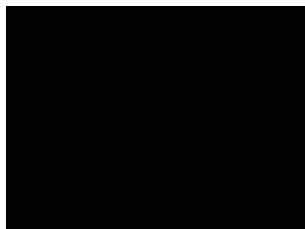
Key components of this support programme include supporting services with safety planning, using resources such as The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) '[Safer services: A toolkit for specialist mental health services and primary care](#)', which includes guidance for mental health services to work jointly with local substance misuse services and having specific training in place for staff on substance misuse assessment. I know that the South East region suicide prevention lead is working to raise awareness and escalate concerns regarding 'shamanic hallucinogenic drugs' via relevant forums to increase awareness and understanding of this risk factor. Furthermore, based on the insights provided in this report, the NHSE/I National team will share any outputs and learning generated by the South East regional team with all other suicide prevention regional leads and teams nationally.

In addition to this, as part of the NHS Long Term Plan's commitment to transform community mental health services, we are investing £181M in psychological therapies for severe mental illness (SMI). This includes the roll-out of 'understanding psychosis and bipolar disorder' training, which will be rolled out across staff working in community mental health teams over the next three years. The aim of this training is to ensure those working with people presenting with psychosis recognise the diverse bio-psycho-social factors (including substance use) that can impact upon a person's mental health.

Your concerns around the lack of awareness of Shamanic hallucinogens are noted. It would be relevant that colleagues at Public Health England are better placed to consider this in their work on "Misuse of illicit drugs and medicines guidance". I have shared your report and our response with my colleague Yvonne Doyle.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,



**National Medical Director
NHS England and NHS Improvement**

