Department of Health & Social Care

From Gillian Keegan MP
Minister of State for Care and Mental Health

39 Victoria Street
London
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Ms Caroline Jones
HM Assistant Coroner, Cambridgeshire and Peterborough
HM Coroner's Office
Lawrence Court
Princes Street
Huntingdon PE29 3PA

10 December 2021

Dear Ms Jones,

I am writing in relation to the Prevention of Future Deaths report issued on 29 July 2021, which came to the Department's attention on 27 September 2021, about the death of James Nowshadi. I am replying as Minister with responsibility for mental health and I am grateful for the additional time in which to do so.

Firstly, I would like to say how very sorry I was to read the circumstances of Mr Nowshadi's death and I offer my deepest condolences to his family and all who loved and knew James. I can appreciate that his loss, at such a young age and in such circumstances, is deeply distressing.

I share your concerns about the ease with which a person can obtain chemicals, such as that mentioned in your report, for the purpose of taking their own life, and I can assure you that in relation to this specific chemical, we are taking action with other Government departments, health bodies, academic experts on self-harm and suicide prevention, and third sector stakeholders, to look at how to tackle the use of this and similar chemicals in suicides.

As part of this work, NHS England and NHS Improvement advises that a communication will be sent to mental health trusts to bring their attention to the risks associated with this chemical as a means of suicide and the need to seek advice from the National Poisons Information Service (NPIS).

The chemical used in this case is available to the public for legitimate uses. However, it is also included in The Poisons Act 1972 as a reportable substance. This means that while this chemical is generally available without the need for a licence, sellers (including online sellers) are obligated to make suspicious transaction reports, whether they process the transaction or not, where they have grounds to believe that the sale is for an illicit use.

Officials inform me that the Home Office regularly engages with suppliers to help them meet their requirements under the Poisons Act and that the Home Office provides detailed guidance[1] in relation to any additional safeguarding steps suppliers could take.

More broadly, as detailed in the fifth progress report of the suicide prevention strategy, published in March 2021[2], it is important that we identify trends in methods of suicides as quickly as possible and put in place interventions to rapidly tackle any emerging methods identified. A process has been established with partners and across Government to rapidly signpost emerging methods and take actions through a multi-agency approach. This includes, but is not limited to, limiting access to the method, reducing or removing promotional material where possible, and providing clearer warnings of risk.

Trust Serious Incident Investigation

I have noted the comments in your report in relation to the investigation conducted by the Cambridgeshire and Peterborough NHS Foundation Trust.

I am advised by the Trust that the Medical Director and the Chief Executive met Mr Nowshadi's family to understand their concerns. A subsequent review of the Serious Incident investigation report identified that reference was made to this chemical. I have received assurance that the Trust is working with the family to ensure lessons are learnt regarding this chemical being used as a method of suicide, and that the risks associated with it are addressed as part of the Trust's Zero Suicide work.

Guidance on use of antidote

In relation to your third matter of concern, in preparing this response, my officials have made enquiries with the UK Health Security Agency and I am informed by the NPIS that its internet database, TOXBASE, has pages on sodium nitrate/nitrite and methylthionium chloride ('mythylene blue') but that it appears these were not accessed from anywhere in the Cambridge area on 31 March 2020 and 1 April 2020.

The NPIS advise that TOXBASE cannot provide advice for every potential clinical scenario or eventuality following poisoning. However, if the NPIS had been contacted regarding this case (a 24-hour telephone advice line is staffed by specialists in poisons information), more specific clinical management advice could have been provided, with support from on call toxicologists if necessary.

Finally, we know how crucial it is that information about a suicide is treated with the utmost sensitivity it deserves, not only for the bereaved families and communities, but also because reporting on the particulars of an individual suicide can lead to other people taking their life in similar ways, be that in the same location or by the same method. With this in mind, and with due respect to the Chief Coroner's rights under the Coroners (Investigations) Regulations 2013 to publish this response, I wish to reiterate the need for

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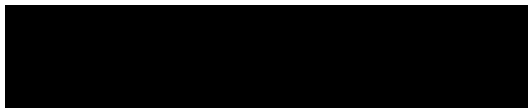
[1] Supplying explosives precursors and poisons - GOV.UK (www.gov.uk)

[2] Suicide prevention in England: fifth progress report - GOV.UK (www.gov.uk)

us, as far as possible, to ensure the media practice caution when making public any facts or details relating to this method.

I hope this response is helpful. Thank you for bringing these concerns to my attention.



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