



Department  
of Health &  
Social Care

*From Nadine Dorries MP  
Minister of State for Patient Safety,  
Suicide Prevention and Mental Health*

39 Victoria Street  
London  
SW1H 0EU

Our Ref: [REDACTED]

Mr Richard Travers  
HM Senior Coroner, County of Surrey  
HM Coroner's Court  
Station Approach  
Woking GU22 7AP

15 February 2021

Dear Mr Travers

Thank you for your letter of 4 January 2021 to Matt Hancock concerning the death of Linda Joan Gillchrest. I am responding as Minister with responsibility for mental health and suicide prevention.

Firstly, I would like to say how deeply saddened I was to read of the troubling circumstances surrounding Mrs Gillchrest's death and I offer my heartfelt condolences to her family and loved ones at this difficult time.

I note your concerns that information about suicide methods is so readily available on the Internet and that the means to assist suicide with this substance can be easily sourced and bought online.

I wish to assure you that suicide prevention is a priority for this Government, and we are working across local and national government to reduce suicide rates so that fewer such tragedies occur each year.

We continue to take action to reduce suicide rates through the Suicide Prevention Strategy for England<sup>1</sup> and the first Cross-Government Suicide Prevention Workplan<sup>2</sup>, which sets out an ambitious programme across national and local government and the NHS. The Workplan includes actions to reduce access to the means of suicide, including through harmful online content.

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<sup>1</sup> <https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england>

<sup>2</sup>

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/772210/national-suicide-prevention-strategy-workplan.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/772210/national-suicide-prevention-strategy-workplan.pdf)

I am advised that suicide prevention policy leads in the health system, at the Department of Health and Social Care, Public Health England (PHE), and NHS England and NHS Improvement (NHSEI), are alert to the risk posed by websites promoting suicide methods, and their direction on the use of certain chemicals in completing suicide, including the substance taken by Mrs Gillchrest. These organisations, along with key stakeholders and academics, are looking at what data is available on suicides by this method and at what steps we can take to stop further loss of life by this method.

The concerns that Mrs Gillchrest's death raises sit within the policy remit of a range of Government departments, including the Department for Digital, Culture, Media and Sports (DCMS) for its work on online harms; and the Home Office (HO) for its work on the sale of reportable substances<sup>3</sup>. Officials have shared your concerns with those Departments and are working with officials from those and other Government departments to explore what further steps we can take to prevent further tragedies, both for this chemical, and any other emerging methods.

There is work already taking place that directly and indirectly impacts some areas of concern. As you may be aware, in 2019, DCMS published its Online Harms White Paper<sup>4</sup>, which set out a range of legislative and non-legislative measures detailing how the Government is planning to tackle online harms, including harmful materials on self-harm and suicide.

On 15 December 2020, DCMS published its response to the White Paper consultation, setting out how the proposed legal duty of care on online companies will work in practice and gives them new responsibilities towards their users. DCMS also announced that the Government has asked the Law Commission to examine how criminal law will address the encouragement, assistance and incitement of self-harm.

In relation to your concerns about the chemical that Mrs Gillchrest procured online, I understand that the HO has produced guidance for businesses on the sale of explosives precursors and poisons<sup>5</sup>. This includes the substance used in this case, which is a reportable poison under the Poisons Act 1972<sup>6</sup>. This means that it is generally available to members of the public without the need for a licence, but sellers, including online sellers, are obligated to make suspicious transaction reports where they have grounds to believe that the sale is for an illicit use.

The HO regularly engages with suppliers to help them meet their requirements under the Poisons Act and provide detailed guidance in relation to any additional safeguarding steps they may wish to take. Generally online marketplaces maintain their own policies on

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<sup>3</sup> Guidance: supplying explosives precursors and poisons  
<https://www.gov.uk/government/publications/supplying-explosives-precursors/supplying-explosives-precursors-and-poison>

<sup>4</sup> <https://www.gov.uk/government/consultations/online-harms-white-paper>

<sup>5</sup> <https://www.gov.uk/government/publications/supplying-explosives-precursors/supplying-explosives-precursors-and-poison>

<sup>6</sup> <https://www.legislation.gov.uk/ukpga/1972/66>

prohibited items, many of which will include a prohibition on the sale of poisons. It is the seller's obligation to check that items they are listing are permitted by their own policies and to take any action where it is appropriate.

In addition to the cross-Government group set up to put in place steps to tackle emerging methods of suicide, officials at the Department of Health and Social Care have also invited HO officials to brief partners in NHSEI, PHE and suicide prevention stakeholders on what HO can do to ensure that sellers of these chemicals are aware of their potential use in suicide, and what can be done to get specialist support to those who might be at risk.

More generally, from 2019/20, we are investing £57million in suicide prevention through the NHS Long Term Plan<sup>7</sup>. This will see investment in all areas of the country by 2023/24 to support local suicide prevention plans and establish suicide bereavement support services.

In addition, every local authority now has a multi-agency suicide prevention plan in place. We are working with local government to assure the effectiveness of those plans, and we invested almost £600,000 in 2019/20 to support local authorities to strengthen their plans.

Furthermore, PHE is piloting a national real-time surveillance system to monitor suspected suicide, by collecting early real time data which can be used to identify patterns of risk and causal factors, to inform national and local responses. HM Treasury has announced £1.2million funding to help support the development of the national system.

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 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.

15 February 2021



**NADINE DORRIES**  
**MINISTER OF STATE FOR PATIENT SAFETY, SUICIDE PREVENTION AND MENTAL HEALTH**

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<sup>7</sup> <https://www.longtermplan.nhs.uk/>