Department of Health & Social Care

From Maria Caulfield
Parliamentary Under Secretary of State
Department of Health & Social Care

39 Victoria Street
London
SW1H 0EU

[redacted]

Michael Wall
Assistant Coroner
Area of Nottingham City and Nottinghamshire

[redacted]

7 June 2024

Dear Mr Wall,

Thank you for the Regulation 28 report to prevent future deaths dated 29 February 2024 about the death of Daniel Mark Edward Tucker. I am replying as Minister with responsibility for Mental Health and Women's Health Strategy.

Firstly, I would like to say how deeply saddened I was to read of the circumstances of Daniel Tucker's death, and I offer my sincere condolences to their family and loved ones. I can only begin to imagine the effect that this will have had on his loved ones and, whilst I know that it will come as little comfort to them, I nevertheless hope they will accept my heartfelt condolences.

In preparing this response, Departmental officials have made enquiries with NHS England.

On your concern regarding ingestion of [redacted], Ambulance Emergency Operation Centres (EOCs) use one of two approved triage tools to take 999 emergency calls – Medical Priority Dispatch System (MPDS) or NHS Pathways. At the time of the calls being made to East Midlands Ambulance Service NHS Trust (EMAS) in Mr Tucker's case, EMAS were users of the protocols within the MPDS. This protocol generates a specific 'Determinant Code' for overdose, following the initial assessment of the patient. This then allows the relevant Ambulance Emergency Operation Centre (EOC), in this case that of EMAS, to locally determine and apply a local response mode or 'Category'. The response modes are underwritten by the NHS England Emergency Call Prioritisation Advisory Group (ECPAG) and sent to NHS Ambulance Service Trusts in England for implementation.

The MPDS does specifically code some common overdose/poisoning agents, but this is for the provision of specific therapies and information for responders rather than for specific

response assignment. The listing of all possible fatal agents would likely lead to significant over-triage and delay as many of these patients are asymptomatic and do not represent pre-arrival emergencies.

The code assigned to intentional overdose (intent to harm self) cases, specifically patients without priority symptoms, is intentionally isolated so that agencies can prioritise intentional acts and respond appropriately, regardless of the substance information offered by the caller. Due to the broad spectrum of potentially dangerous substances that can be ingested by members of the public, either intentionally or accidentally, coupled with the urgent and emergency care (UEC) challenges and delayed response times currently faced by the NHS, it is recommended by the MPDS (and NHS England) that ambulance trusts utilise trained clinicians in the control centre to advise further on the potential effect of ingestions and upgrade responses if deemed necessary. The MPDS also has protocols for overdose patients as well as those patients with mental health conditions that are suffering any self-harm or suicidal thoughts. Since the time of this call, specific training and a new protocol have been developed specifically for first party callers in crisis.

EOCs follow specific principles to ensure clinical oversight for patients calling and presenting with overdose and suicidal ideations. These principles have been reviewed and strengthened through several national recommendations since 2019.

NHS England issued guidance for Ambulance Services relating to overdoses and suicidal intent in April 2021. The guidance highlights the critical importance of clinical oversight and review and sets out that where an overdose is declared, further clinical intervention should take place, or the case should be automatically upgraded if this does not occur within a specified time (30 minutes). This is for use by experienced clinicians and lends itself more to a consultation-led assessment rather than triage. Most recently, the overdose guidance was updated in November 2023 to include callers who reach a Category 5 disposition (hear and treat). This followed a review by the Emergency Call Prioritisation Advisory Group (ECPAG, NHS England) and the National Ambulance Service Medical Director's Group (NASMeD, Association of Ambulance Chief Executives) to ensure it remained clinically fit for purpose.

I also understand that Joint Royal Colleges Ambulance Liaison Committee (JRCALC) who produce clinical guidelines for UK paramedics is currently working with the National Poisons Information Service (NPIS) colleagues/experts to update the JRCALC overdose and poisoning guidance.

The Government has taken steps to reduce access to and awareness of this substance. DHSC has led an emerging methods working group to prevent awareness and access to substances such as this one. This involves close working across government and with others to ensure rapid, targeted action has been taken to prioritise tackling the substance in question. The working group involves representatives from the voluntary, community and social enterprises sector, police as well as government departments including the Home Office and The Department for Science, Innovation and Technology as well as academics and the NHS. There are currently over 30 live actions and interventions that collectively are reducing public access to methods, including by reducing the sale and importation of

methods where appropriate as well as reducing references to, and limiting awareness of, emerging methods.

The group has worked with business, including online suppliers and manufacturers of the substance, to significantly reduce access. We have also worked with major online suppliers also remove it from sale to individuals in its pure form. We continue to work operationally with our broader partners, including Border Force and the police on interventions to reduce access to this specific substance for the purpose of suicide. These actions are kept under operational review.

I would also like to assure you that the Government has also taken action to address the prevalence of harmful suicide and self-harm content online such as the website you highlighted. For example, as you will be aware, the Online Safety Act, when fully in force, will require all services in scope to rapidly remove regulated content that meets the criminal threshold once they become aware of it, this includes illegal suicide and self-harm content. Under the Act, search services also have targeted duties that require them to minimise the risk of users encountering illegal search content, such as those found on this specific website. There is also a requirement for search services to take or use, where proportionate, user support measures. The regulator now responsible for online safety, Ofcom, will recommend measures that search services can put in place to achieve these objectives. These could include removing results for sites that are known to host illegal suicide and self-harm content, as well as signposting users towards sources of support.

The Act provides Ofcom with a robust suite of enforcement powers, including business disruptions measures and significant fines for use in the case of non-compliance. The Government has also worked with internet service providers, tech companies and social media platforms, as well as expert advisors such as the Samaritans, to tackle harmful pro-suicide forums such as this one.

In addition, in September 2023 the multi-sector and cross-government suicide prevention strategy for England was published. The five-year strategy set out over 130 actions aimed at reducing the rates of suicide in England.

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

Yours sincerely,

MARIA CAULFIELD