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

[redacted]

[redacted]
Our Ref: [redacted]

Mr Colin Phillips
Acting Senior Coroner, Swansea and Neath Port Talbot
Coroner's Office
Civic Centre
Oystermouth Road
Swansea SA1 3SN

2 February 2021

Dear Mr Phillips

Thank you for your letter of 9 December 2020 about the death of Samuel Morgan.

I was deeply saddened to read the circumstances of Sam's death and wish to offer my most heartfelt sympathies and condolences to Sam's family and loved ones at this difficult time.

My officials have liaised with the Medicines and Healthcare products Regulatory Agency (MHRA) which I know has considered carefully your comments about the presentation of risks associated with citalopram and other selective serotonin reuptake inhibitor (SSRI) medicines on Patient Information Leaflets, and by extension the presentation of major risks associated with all prescribed medicines.

I hope the MHRA's response is helpful in explaining that the development of Patient Information Leaflets in the UK is supported by extensive user testing to shape the presentation of key safety messages and that the MHRA cannot identify any evidence that adopting a similar approach to the United States of 'black box' warnings is more effective in communicating risk. Nevertheless, should new data come to light, the MHRA will review if changes could be made to support risk communication in future. In addition, the MHRA has created a Yellow Card with the information you have provided in your report. As you will know, the MHRA's Yellow Card report system enables it to monitor the safety of medicines.

Every suicide is a preventable tragedy. While Health is a devolved matter, I can advise what action we are taking in England to reduce suicides, particularly amongst young men, who we know are at high risk.

In England, suicide prevention is a priority for this Government and we continue to take action through the Suicide Prevention Strategy for England and its subsequent progress reports, as well as through the first cross-Government Suicide Prevention Workplan, which sets out an ambitious programme across national and local Government and the NHS to reduce suicides.

We have issued guidance to local authorities that highlights the importance of working across all local services, including the voluntary sector, to target high risk groups such as men. Every local authority now has a suicide prevention plan in place and 97 per cent of these include action to reduce risk of suicide in men.

From 2019/20, we are investing £57million in suicide prevention through the NHS Long Term Plan. 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. We have ensured that the suicide prevention funding for local areas is used to test different approaches to reaching and engaging men.

Finally, I note your concern that a medical review was not scheduled to be held with Sam one week after the antidepressants were prescribed and that this is not in line with the recommendations of the National Institute for Health and Care Excellence (NICE) clinical guideline 90[1], which states:

1.5.2.7 A person with depression started on antidepressants who is considered to present an increased suicide risk or is younger than 30 years (because of the potential increased prevalence of suicidal thoughts in the early stages of antidepressant treatment for this group) should normally be seen after 1 week and frequently thereafter as appropriate until the risk is no longer considered clinically important.

Clinicians are expected to take account of NICE guidelines, product information and advice in the BNF when discussing treatment options with a patient, ensuring that patients are aware of known risks associated with medicines so that properly informed decisions are taken. The risk of suicidal behaviour associated with SSRIs, particularly in young people aged up to 25 years, has been highlighted to healthcare professionals via MHRA Drug Safety Updates, as well as in published guidance by the MHRA[2]. The GP handbook, the British National Formulary (BNF) also highlights these risks and the importance of monitoring particularly at the start of treatment.

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

Yours sincerely,

NADINE DORRIES

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

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[1] https://www.nice.org.uk/guidance/cg90/chapter/Recommendations

[2] https://www.gov.uk/government/publications/ssris-and-snris-use-and-safety/selective-serotonin-reuptake-inhibitors-ssris-and-serotonin-and-noradrenaline-reuptake-inhibitors-snris-use-and-safety