The
Coroner's
Service

North London Coroner's Service,
Barnet, Brent, Enfield, Haringey and Harrow,
Barnet Coroner's Court,
29 Wood Street, London, EN5 4BE
Clerk to the Senior Coroner
[redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

Secretary of State for Digital, Culture,
Media and Sport
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100 Parliament Street
London SW1A 2BQ

Damian Collins MP
House of Commons
London
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100 New Bridge Street
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1 Hacker Way
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Snap Inc
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CA 90405 USA

Twitter International Company
c/o Trust & Safety – Legal Policy
One Cumberland Place
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1	**CORONER** I am Mr Andrew Walker, H M Coroner and senior coroner, for the coroner area of Northern District of Greater London
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On the 21st November 2017 I opened an investigation touching the death of Molly Rose Russell, aged 14 years old. I opened an inquest on the 1st December 2017. The inquest concluded on the 30th September 2022. The conclusion of the inquest was "Molly Rose Russell died from an act of self-harm whilst suffering from depression and the negative effects of on-line content". The medical cause of death was 1a Suspension.
4	**CIRCUMSTANCES OF THE DEATH** Molly Rose Russell was found having hanged herself [redacted] on the Twenty- First of November 2017. Molly was 14 years old. Molly appeared a normal healthy girl who was flourishing at school, having settled well into secondary school life and displayed an enthusiastic interest in the Performing Arts. However, Molly had become depressed, a common condition affecting children of this age. This then worsened into a depressive illness. Molly subscribed to a number of online sites. At the time that these sites were viewed by Molly some of these sites were not safe as they allowed access to adult content that should not have been available for a 14-year-old child to see. The way that the platforms operated meant that Molly had access to images, video clips and text concerning or concerned with self-harm, suicide or that were otherwise negative or depressing in nature. The platform operated in such a way using algorithms as to result, in some circumstances, of binge periods of images, video clips and text some of which were selected and provided without Molly requesting them. These binge periods, if involving this content are likely to have had a negative effect on Molly. Some of this content romanticised acts of self- harm by young people on themselves. Other content sought to isolate and discourage discussion with those who may have been able to help. Molly turned to celebrities for help not realising there was little prospect of a reply. In some cases, the content was particularly graphic, tending to portray self-harm and suicide as an inevitable consequence of a condition that could not be recovered from. The sites normalised her condition focusing on a limited and irrational view without any counterbalance of normality. It is likely that the above material viewed by Molly, already suffering with a depressive illness and vulnerable due to her age, affected her mental health in a negative way and contributed to her death in a more than minimal way.

5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows. – The following matters were raised during the Inquest:- 1. There was no separation between adult and child parts of the platforms or separate platforms for children and adults. 2. There was no age verification when signing up to the on-line platform. 3. That the content was not controlled so as to be age specific. 4. That algorithms were used to provide content together with adverts. 5. That the parent, guardian or carer did not have access, to the material being viewed or any control over that material. 6. That the child's account was not capable of being separately linked to the parent, guardian or carer's account for monitoring. I recommend that consideration is given by the Government to reviewing the provision of internet platforms to children, with reference to harmful on-line content, separate platforms for adults and children, verification of age before joining the platform, provision of age specific content, the use of algorithms to provide content, the use of advertising and parental guardian or carer control including access to material viewed by a child, and retention of material viewed by a child. I recommend that consideration is given to the setting up of an independent regulatory body to monitor on-line platform content with particular regard to the above. I recommend that consideration is given to enacting such legislation as may be necessary to ensure the protection of children from the effects of harmful on-line content and the effective regulation of harmful on-line content. Although regulation would be a matter for Government I can see no reason why the platforms themselves would not wish to give consideration to self-regulation taking into account the matters raised above.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by Wednesday the 8th of December 2022 I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons;- The Family. The Parties.
9	**Date** 13th October 2022 Andrew Walker H.M. Coroner Mr Andrew Walker