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National Medical Director
NHS England
Wellington House
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13th October 2025

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Jessica Lynda Smithson who died on 28th August 2024.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 8 August 2025 concerning the death of Jessica Lynda Smithson on 28 August 2024. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Jessica's family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised in respect of the circumstances surrounding Jessica's death have been listened to and reflected upon.

Your Report raised the concern that there currently is not a 24/7 crisis text service in every [Integrated Care Board](#) (ICB) across England, despite the critical role such services play being highlighted in the [National Suicide Prevention Strategy 2023](#) for England. You also raised that there has been a delayed roll out, and the current gap in provision means that a health-related service is being provided by charity organisations who have differing policies and processes regarding the immediate risk to life, and who have a limited ability to understand local mental health NHS pathways.

Anyone in England can access age-appropriate crisis support by calling NHS111 and selecting the '[mental health option](#)', with services commissioned and designed to deliver consistent triage, risk assessment and, where necessary, rapid face-to-face assessments. To further enhance accessibility, NHS England has requested that all ICBs put in place integrated crisis text services and ICBs have now submitted their plans, with delivery expected across all areas by Spring 2026.

We would suggest the Coroner's Office approaches the charity directly for further information about the support provided, if required. As this is a non-NHS provider, we are unable to comment on their service delivery arrangements or clinical governance processes.

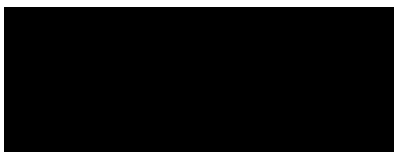
Your Report also directed some concerns to NHS Greater Manchester ICB (GM ICB), regarding the current lack of a locally commissioned service and the implications of

this. As your Report has also been sent to GM ICB, they will respond to those concerns separately and NHS England will review this and consider any further actions required.

I would also like to provide further assurances on the national NHS England work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors, and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around events, such as the sad death of Jessica, are shared across the NHS at both a national and regional level and helps us to pay close attention to any emerging trends that may require further review and action.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,

A large black rectangular box redacting the signature of the National Medical Director.A black rectangular box redacting the name of the National Medical Director.

National Medical Director
NHS England