REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] Secretary of State for Health and Social Care, 39 Victoria Street, London SW1H 0EU 2. [redacted] Chief Executive Officer, NHS England, Premier House, 60 Caversham Road, Reading, RG17EB 3. [redacted], Chief Executive Greater Manchester Integrated Care Board, NHS GM, 4th Floor, 3 Piccadilly Place, Manchester M1 3BN
	CORONER I am Joanne Kearsley, Senior Coroner for the Coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION AND INQUEST** On the 9th September 2024 I commenced an investigation into the death of Jessica Lynda Smithson. The Inquest concluded on the 7th August 2024. The medical cause of death was 1a) Hanging The conclusion of the Inquest was Suicide.
4	**CIRCUMSTANCES** Jessica was 27 years old and had a diagnosis of Emotional Unstable Personality Disorder. She was under the care of Pennine Care NHS Foundation Trust. At the time of her death her mental health was stable and there were no concerns about her. On the 27th August 2024 Jessica made an allegation to Greater Manchester police of a serious sexual assault which she indicated had occurred on the 26th August 2024. On the 28th August she attended an examination in support of her allegation and returned home at approximately 20:30 hours. At 21:07hrs Jessica contacted a crisis text mental health service. Her care co-ordinator told the court Jessica preferred a text service to ringing a NHS crisis telephone line where you would speak to someone. The text exchange lasted until 21:44hrs at which stage Jessica ended the conversation. I found from the information she provided in her messages that at the time she stopped the call she was in the process of [redacted] which she used to end her life. The text crisis service did not know her name or location. However, this particular service have an arrangement with the Metropolitan Police who have the power to try and locate anyone using this crisis service who is at real immediate risk. The text crisis service did not contact the Metropolitan police regarding Jessica and I found they should have done so given the content of her messages. I did find that her death would not have been averted even if contact had been made. During the course of the Inquest I heard evidence that this charity alone have supported over one million individuals since their launch in 2019. On average they receive 1500-2000 crisis texts per day and are contacting police forces with, on average, 28 cases per day where there is a real and immediate risk to life.

A large number of people accessing this service are aged 13-24. In addition, the number of people under the age of 13 who are using this service is significantly increasing.

53. **CORONER'S CONCERNS**

During the course of the investigation evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows:-

Department of Health and NHS England

1. In 2023 the National Suicide Prevention Strategy 2023 for England highlighted the critical role of 24/7 crisis text services. The roll out of crisis text services across the country in 2024/25 was a key action and commitment in the Strategy, funded by an allocation of £7million to ICBs included in the NHSE Urgent and Emergency Care recover Plan.

   (a) The NHSE indicated in their April 2024 Crisis Text Support Guidance and Specification document that they will oversee the rollout of these services which was expected to be rolled out by the end of March 2025. This has now been extended to March 2026.As of to date the evidence indicates only 10 have set up such a service with another 11 in the process of doing so. Some ICBs have indicated that they have no plans to do so.

   (b) At present this gap in a health-related service is being filled by charity organisations who have different policies and processes regarding actions to be taken if a person is at immediate risk of suicide. The charities are not under the Department of Health so there is no standard policy or procedure for them to follow if there is a real and immediate risk to a service users' life.

   Hence there is a lack of consistency as to the support an individual can receive when there is an immediate risk to their life, for example whilst the charity involved in this case have an agreement with the Metropolitan Police Service to help locate someone whose whereabouts are unknown, this is not the case for all charities.

   In addition, as they are not linked into local NHS Trusts, they have limited ability to understand local mental health NHS pathways or to offer a more co-ordinated response where someone is already under local mental health services.

Greater Manchester Integrated Care Board

2. Within the Greater Manchester Area there is no commissioned crisis text mental health support service. Whilst GM residents can message national services, often the location of an individual texter will not be known.

   Th court heard from Greater Manchester Police that they receive a significant number of referrals which have been sent by this crisis service to the Metropolitan Police, almost one a day where there has been a real and immediate risk to a person's life identified. All of these referrals require an immediate police response (they are outside of Right Care Right Person). If there was a GM commissioned service, it is likely that any search for the location of the individual would be done by GMP and would shorten the timeframe in which they could respond to the risk.

   In addition, a GM commissioned service would have a greater understanding of local pathways in order to refer people who may have a deteriorating mental health before they reached the point of crisis.

6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 **06th October 2025**. 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 namely: - Family of Jessica Smithson Metropolitan Police Mental Health Innovations Pennine Care NHS Foundation Trust I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary from. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me the coroner at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	Date: **08th August 2025** Signed: