

Mr Xavier Mooyaart

Assistant Coroner for Inner South London
Southwark Coroner's Court
1 Tennis Street
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National Medical Director

NHS England
Wellington House
133-155 Waterloo Road
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By Email:

7 April 2026

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Simon Moss, who died on 14th February 2024.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 1st February 2026 concerning the death of Simon Moss on 14th February 2024. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Simon's family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Simon's care have been listened to and reflected upon.

Your Report raises concerns that there is a gap in training, practice and policy and/or procedural frameworks relating to the use of the Electronic Patient Care Record as a source of information when conducting mental health assessments in hospital.

Through the [Culture of Care national programme](#), NHS England is supporting mental health trusts to strengthen both the effective use of clinical information and relational approaches to care, in inpatient settings. This includes supporting mental health staff to know the person, understand their history, and engage with family, friends and carers to better recognise and respond to risk. Trusts are beginning to apply these principles more broadly across community services.

The recently launched NHS England [Staying safe from suicide guidance](#) was co-produced by mental health nurses and published by NHS England in June 2025. Its aim is to address issues in terms of mental health assessments both in a crisis situation and when mental health nurses are undertaking detailed mental health assessments in mental health and acute physical health trusts. This guidance supports the government's work to reduce suicide and improve mental health services. It promotes a shift towards a more holistic, person-centred approach rather than relying on risk prediction, which is unreliable because suicidal thoughts can change quickly. Instead, it recommends using a method based on understanding each person's situation and managing the safety. It highlights the importance of bringing in families/carers in gaining an overall understanding and need for safety planning. Training to support this guidance was launched in 2025 and is available via an e-learning module.

This complements existing local training on suicide prevention, and a number of other national e-learning products that are already available.

The work within the [medium-term planning](#) and the [10-year plan](#) commits to co-produced service models which will have significant impact on the service model for adults, one being 'Crisis Assessment Centres' (Mental Health Emergency Departments). The Mental Health Programme Team in NHS England are working with regions and local systems to develop 85 new dedicated Mental Health Emergency Departments to make sure people experiencing crisis get effective care. Urgent and emergency care will be redesigned to avoid the need for unnecessary hospital attendance or admission. People with mental health difficulties need a range of options in a crisis, including alternatives to hospital.

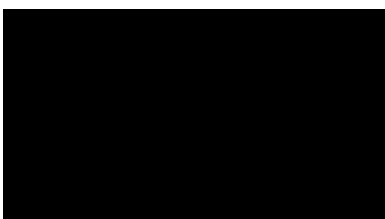
Regional Response

The NHS England London Region Team have liaised with South East London [Integrated Care Board](#) (ICB) about the concerns you have raised. They have advised that the University Hospital London now ensures that next of kin details are added to patient information during the triage process. They are also ensuring that information from the London Ambulance Service is added to their Emergency Department (iCare) system. They advised that South London and Maudsley Mental Health Trust has introduced a new induction form to be completed by all new bank and locum staff which provides details on how to access the electronic patient record and London care record systems. There is now greater awareness amongst staff of the valuable information relevant to mental health assessments that may be on the electronic patient care system.

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 Simon, 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,



National Medical Director
NHS England