REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **1. [redacted] Chief Executive Officer (CEO), NHS England, Wellington House, 133-155 Waterloo Road, London SE1 8UG**
1	**CORONER** I am Xavier Mooyaart, Assistant Coroner for the coroner area of Inner South 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 19 February 2024 the court commenced an investigation into the death of Simon Moss, 49. The investigation concluded at the end of the inquest on 16 December 2025. The conclusion of the inquest was that of suicide leading to a medical cause of death of multiple injuries. Interested Persons were invited to make submissions on a regulation 28 report following the Christmas break.
4	**CIRCUMSTANCES OF THE DEATH** Mr Moss was discovered on the roof of the family home on the morning of 14 February 2024. He had recently developed paranoid thinking and was extremely anxious. It was apparent that he was considering suicide. Emergency Services attended. London Ambulance Service made extensive notes of the concerns of his wife, behaviour, inconsistencies in his account, and indications that he was not being open about this thinking. These were recorded in an Electronic Patient Care Record ("EPCR"). Mr Moss was taken to hospital and triaged for review by the mental health liaison team. The triage nurse made a brief referral note, which was a distillation of the triage handover from the ambulance crew, itself a distillation of their EPRC. The mental health assessment was conducted without reference to the information set out in the EPCR, and relied on the triage referral note and the evidence provided by Mr Moss. He denied suicidal ideation, cited protective factors, etc. He denied having contact details for his wife. These contact details were recorded in the EPCR and ordinarily she would have been called as part of the assessment. Mr Moss was subsequently discharged later that morning. The evidence was that had his wife been called she would have provided collateral information to mental health staff on the extent of his risk to self and would have attended to collect him had she been told of his discharge (she was not). Mr Moss immediately went to a nearby building of height and deliberately fell to his death that same day (14 February 2024).

5	**CORONER'S CONCERNS** During the course of the inquest the 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. – The EPRC contained a detailed account of the reasons for which the ambulance paramedics considered the patient at risk to self. It provided a record of details and issues that would have been important to explore in a mental health assessment, including indicators that the patient's own account could not be relied on. However, the evidence was that in his subsequent mental health assessment only the triage referral note made by the triage nurse in A&E was relied on, together with the patient's account. That triage note was necessarily brief and so the detail in the EPCR was lost. Furthermore, the Manchester Triage System only provided the option of "suicidal ideation" or "self-harm" whereas there was evidence in the EPCR of planning and intent. Further, neither the referral, nor broader medical records contained the contact information of his wife who had called the emergency services. Her mobile number was on the EPCR. Trust policy was that she should have been called as part of his assessment. She was not as the patient would not disclose her number and the EPRC was not consulted. *The evidence was that across several experienced mental health nurses present – who had worked across many roles and mental health trusts – none knew of, or thought to look for the EPCR for further collateral or to seek next of kin details through this or other means.* The EPCR was accessible on systems available to the mental health nurse however. While remedied at the relevant trust, given the evidence of broader practice among mental health nurses I am concerned that there remains a gap in training, practice, policy and/or procedural frameworks for mental health assessments leading to an important source of significant information (EPRC narrative and family contact details) not being known of or used, which would otherwise: (a) inform an accurate evaluation of the risk to self of patients presenting with mental health illness via ambulance services (i.e. this was not an isolated incident of the EPCR not being known of or used by the specific mental health nurse making the assessment) by (i) providing an independent and detailed account of recent patient history and (ii) contact details for family/friends/individuals who can provide further collateral on their recent presentation, and (b) allow better mitigation of residual risks at the point of discharge (e.g. through engagement with family and ensuring the patient is collected). I am concerned that this may undermine the evaluation and mitigation of risk in patients presenting with potential risk-to-self and so represents a risk of future deaths.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 Tuesday 31st March 2026. 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: • Family, • London Ambulance Service, • Metropolitan Police Service, • Lewisham and Greenwich NHS Trust, and • South London and Maudsley NHS Foundation Trust. I have also sent it to Professor [redacted], General Secretary and Chief Executive of the Royal College of Nursing who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. The Chief Coroner may publish either or both in a complete or redacted or summary form. 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.
9	[redacted] **1s February 2026**