Mr. Paul Rogers
Assistant Coroner for Inner West London
Inner West London Coroner's Court
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London
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National Medical Director
NHS England
Wellington House
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SE1 8UG

[redacted]

23rd June 2026

[redacted]

Dear Mr Rogers,

Re: Regulation 28 Report to Prevent Future Deaths – Edward Muwanga who died on 7th August 2023.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 24th April 2026 concerning the death of Edward Muwanga on 7th August 2023. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Edward's family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Edward's care have been listened to and reflected upon.

Your report raised concerns around the sharing and visibility of important health care records between medical agencies. In this case, particularly between the treating Trust, in this case South London and Maudsley NHS Foundation Trust (SLAM) and NHS 111, and between the Ambulance Service Trust and SLAM.

NHS England is committed to supporting the sharing of critical clinical information across NHS organisations. As of 2021, all primary and secondary care organisations have been able to share a subset of the patient information they hold, the core information standard, between providers within their own integrated care board footprint through their local Shared Care Record.

Building on this and recognising the clinical need, an initiative has been set to achieve national interoperability between shared care records across England. This committed investment aims to enable any authorised health and care professional to have access to safe, reliable, and accurate records, regardless of the patient's location or where care is provided. It is however, up to local shared care record organisations and participating NHS Trusts, to agree what information, in addition to the core information standard, is held and shared through the local shared care record. It is also up to individual NHS Trusts to negotiate data sharing protocols and agreements to enhance localised information sharing outside of the local shared care record.

NHS England recognises that limited information sharing between care settings can reduce the continuity and effectiveness of care, particularly where patients are receiving support across multiple organisations.

NHS England has developed and led the Frontline Digitisation (FD) Programme to support NHS trusts in adopting Electronic Patient Record (EPR) systems, improve digital maturity, and enable better information sharing within and between organisations. In addition to supporting the procurement of EPR systems, the FD Programme provides guidance and oversight to help ensure that implementations are safe and effective.

The South London and Maudsley (SLAM) NHS Foundation Trust

This trust uses the CareNotes Electronic Patient Record (EPR) system supplied by OneAdvanced (formerly Advanced). As part of the Frontline Digitisation (FD) Programme, the Trust was assessed as having an EPR that did not meet the Programme's core standards under the Digital Capability Framework (DCF). Through the FD Programme, the Trust secured funding to support development of a business case to replace its current EPR system.

London Ambulance Service NHS Trust

This Trust uses an electronic Patient Care Record (ePCR) system supplied by Cleric Computer Services Ltd. As part of the FD Programme, the Trust was assessed as having an EPR that did not meet the Programme's core standards under the DCF. Through the FD Programme, the Trust has secured funding to invest in additional functionality to support its EPR, including:

- A new patient centred Computer Aided Dispatch (CAD) system, linked to its mobile electronic Patient Care Record (ePCR) system
- Improved front-line interoperability with other Ambulance Services and One London Emergency Departments (ED) as a pilot.
- Joining up the patient record by linking with ED systems
- Optimisation of the EPR across the Ambulance Trust and associated treatment centres.

Both trusts can already securely share important health care records electronically with health and care partners through the OneLondon Care Record, using a Health Information Exchange (HIE) supplied by Oracle Health. However, while Section 136 status should be recorded within the originating mental health record (in this case SLAM), this would not necessarily be included in the OneLondon Care Record.

Further information about information sharing between providers

Local EPR implementations should operate under the oversight of a Trust Clinical Safety Officer (CSO). The CSO is a registered healthcare professional responsible for overseeing the clinical safety and risk management of health IT systems, helping to

ensure that these systems are safe for patient use. Digital safety is a critical component of patient safety.

Suppliers and Trusts are jointly accountable for compliance with the two mandatory Clinical Risk Management Standards defined under Section 250 of the Health and Social Care Act 2012:

- DCB0129: Clinical Risk Management: its Application in the Manufacture of Health IT Systems - NHS Digital
- DCB0160: Clinical Risk Management: its Application in the Deployment and Use of Health IT Systems

Where multiple digital systems are used within a trust, including EPR systems, robust policies and procedures should be in place to set clear expectations, support appropriate clinical record management, and ensure the timely handover and escalation of abnormal results to the relevant individuals. Responsibility and accountability for the sharing and management of information held within electronic records, including information shared across different systems, rests with each organisation through its established digital governance arrangements.

While the FD Programme supports investment in local digital capability, interoperability is generally configured and managed locally, based on agreements between provider organisations and their technology suppliers, with NHS England regional teams taking account of wider catchment areas where appropriate.

It is also relevant to consider how the Summary Care Record (SCR) and National Care Records Service (NCRS) may have supported clinical care in this case. Given that Edward had a diagnosis of paranoid schizophrenia, it would be reasonable to expect that this diagnosis, together with any medication prescribed for that condition, would be visible in his SCR, provided that he had not opted out. Brief additional clinical information, for example regarding auditory hallucinations, may also have been included. However, the SCR does not contain correspondence and would therefore be unlikely to include communications between SLAM and the police, nor any recent information relating to sections 135 and 136, unless these were identified by the responsible clinician as explicitly needing to be coded or included as additional information for sharing. Similarly, the National Record Locator, as a separate service within NCRS, is also unlikely to contain that specific correspondence.

National Care Records Service (NCRS)

NCRS is the successor to the Summary Care Record application (SCRa) and is designed to address barriers to adoption identified in a number of care settings. The National Care Records Service (NCRS) provides a quick and secure way to access national patient information in order to support clinical decision-making and improve healthcare outcomes. It is free to use and includes additional features and services beyond the legacy SCRa product.

NCRS is internet-based, accessible through a web browser, and is actively used by the London Ambulance Service (LAS) across a range of devices.

We would expect both the LAS and NHS 111 to have access to patients' Summary Care Record (SCR) through NCRS. Any further enquiries about access to SCR through NCRS should therefore be directed to LAS.

Summary Care Record (SCR)

NCRS provides access to patients' Summary Care Records. The SCR is a national record containing key patient information such as current medication, allergies, and details of any previous adverse reactions to medicines. It is generated from GP medical records, and changes made to the GP record are synchronised to the SCR. The SCR can be accessed and used by authorised staff in other parts of the health and care system who are involved in the patient's direct care but do not require access to the full GP record. Its purpose is therefore to provide a concise summary of the patient's GP record, including the information most likely to be helpful during an unscheduled care encounter.

As a minimum, the SCR contains important information about:

- Current medication
- Allergies and details of any previous reactions to medicines
- The name, address, date of birth and NHS number of the patient

In addition, details of long-term conditions, significant medical history, and specific communication needs are now included by default for patients with an SCR, unless they have previously told the NHS that they do not want this information to be shared. For more information, and to illustrate the type of content included in an SCR, an example SCR is available here: Additional Information in the SCR

Where information is communicated to the GP, for example, via discharge summaries, crisis event notifications, or correspondence, relevant details may be coded or attached within the GP record. If appropriately recorded and coded, this can be visible within the Summary Care Record (SCR) as Additional Information. However, this is not guaranteed, as it depends on:

- Whether the mental health provider shares the information
- Whether the GP system receives and codes it
- Whether it is included within the SCR upload and subsequently viewed

Additional Information in the SCR includes the active problems and significant past problems (from Optum/TPP/Medicus provider systems) for a patient as recorded by their registered GP practice.

In relation to SCR, as of 27 April 2026, 88% of the population of England (approximately 59 million patients) had an SCR with Additional Information, 7.3% had

a Core Only SCR (allergies and medications only), and 1.5% had opted out of SCR. In most cases, patients must give Permission to View before their SCR can be accessed. However, an Emergency Access option is available where a patient is unable to provide Permission to View, for example because they are unconscious.

National Record Locator

NHS England's National Record Locator (NRL) service allows health and social care professionals to identify and access patient information shared by other health and social care organisations across England in support of direct patient care. It does this by recording the location of digital and paper records within the NHS and providing an index of pointers or bookmarks that can be used to retrieve key patient information from the source. The aim is to improve interoperability across organisational boundaries and support professionals, including care coordinators in mental health trusts, to retrieve information securely and remotely at the point of need. This can help provide a more longitudinal view of a patient's records and indicate their treatment history. The NRL avoids the need for organisations to create duplicate copies of information across systems by facilitating access to up-to-date information directly from the source. It can also indicate which organisations currently have a care relationship with a patient, enabling users to contact the relevant service in the event of a crisis.

Mental health crisis plans are one of the pointer types supported by the NRL service. NRL does not store mental health data, or clinical content itself; rather, it points users to where that information can be found. NRL information can be accessed through the National Care Records Service (NCRS). Where multiple pointers are returned, users can sort the results by creation date.

If a mental health provider publishes relevant documents (e.g. care plans, discharge summaries), these may be discoverable via NRL. However, there is no consistent assurance that Section 136 status is explicitly shared or published, and visibility depends on local publishing and role based access and governance practices.

Connecting Care Records

NCRS complements Connecting Care Records (ConCR), also known as Shared Care Records, which bring together records from different health and care organisations in one place and connect information around the individual rather than a single organisation. Shared Care Records include prescribed medications and will typically contain more information about an individual than a Summary Care Record.

Responsibility for delivering shared care records rests with local Integrated Care Boards (ICBs). Each ICB develops its shared care record in response to local health and care needs, existing systems, and future plans. As a result, some shared care records are accessible to neighbouring ICBs, while others operate only within their own area. Future plans include improving connectivity so that shared care records can be used more consistently across England, regardless of where a person lives or receives care.

Further investigation may be required to determine the extent of the relevant trusts' access to SCR, NRL and Shared record in this case.

More broadly, NHS England and the Department of Health and Social Care have published Fit for the Future: 10 Year Health Plan for England, which sets out the government's plan for healthcare in England over the next decade. The Plan includes a commitment to give patients 'a single, secure and authoritative account of their data – a single patient record' to support more coordinated, personalised and predictive care.

Regional Response

NHS England have liaised with One London Board who have detailed their response and actions following this Report. As they will be providing a response directly to the Coroner we won't provide further details here.

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 Edward, 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