[redacted]
Parliamentary Under Secretary of State for Patient Safety, Women's Health and Mental Health

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Mr Ian Potter
St Pancras Coroner's Court,
Camley Street,
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[redacted]

15 September 2025

Dear Mr Potter,

Thank you for your Regulation 28 report to prevent future deaths dated 23 June 2025 about the death of Louise Elizabeth Amy Crane. I am replying as the Minister for Mental Health.

Firstly, I would like to say how saddened I was to read of the circumstances of Louise's death, and I offer my sincere condolences to her family and loved ones. The circumstances your report describes are concerning and I am grateful to you for bringing these matters to my attention.

I have noted the contents of your report, and the matter of concern raised regarding a lack of a nationwide policy or approach to anti-ligature measures in mental health settings. In preparing this response, departmental officials have liaised with NHS England who will also be responding to you directly.

The Care Quality Commission have issued guidance for providers about reducing harm from ligatures in mental health wards. This can be found at www.cqc.org.uk/guidance-providers/mhforum-ligature-guidance.

I understand your concerns around the need for a more consistent approach to antiligature measures. I am assured that in recent years NHS England has issued a National Patient Safety Alert and other guidance to providers regarding ligature point risk assessments and tools.

The Patient Safety Alert set out actions to change and update existing policies and procedures, including ensuring that ligature risk assessments were up to date and reflective of latest guidance. We can share, in confidence, more details on the alert with the Coroner on request.

More broadly, NHS England's mental health, learning disability and autism inpatient quality transformation programme will support cultural change and a new model of care for the future across all NHS-funded mental health inpatient settings. Local health

systems have now published their 3-year plans for localising and realigning inpatient care in line with this vision.

We are also committed to delivering the Suicide Prevention Strategy for England, which aims to reduce suicide rates and address the risk factors contributing to suicide, as well as improving support for those who have self-harmed or are bereaved by suicide. The strategy highlights the need to provide tailored, targeted support to priority groups, including those at higher risk. At a national level, this includes people in contact with mental health services.

Personalised approaches to suicide prevention are also important, and locally I understand that North London NHS Trust is a member of the Zero Suicide Alliance and has developed a structured Suicide Prevention Strategy of its own.

I hope this response is helpful. Thank you for bringing these concerns to my attention.

All good wishes,