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HM Assistant Coroner
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[redacted]

National Medical Director
NHS England
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21 August 2025

Dear Mr Potter,

Re: Regulation 28 Report to Prevent Future Deaths – Louise Elizabeth Amy Crane who died on 19 September 2024.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 23 June 2025 concerning the death of Louise Elizabeth Amy Crane on 19 September 2024. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Louise's family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Louise's care have been listened to and reflected upon.

Your report raises the concern that there is a lack of a nationwide policy / approach to anti-ligature measures in mental health settings. My response has been informed by NHS England's regional London and national Mental Health Teams.

In recent years, NHS England has acted upon the concerns raised above and has adopted a comprehensive, nationwide approach to anti-ligature measures. In March 2020, NHS England and Improvement (now NHS England) issued a National Patient Safety Alert specifically addressing ligature and ligature point risk assessment tools and policies, sent via the Central Alerting System to all providers – with mandated executive oversight, and compliance monitored by the Care Quality Commission (CQC). North London NHS Foundation Trust (NLFT) has confirmed to NHS England that it became compliant with this alert on 1 June 2020.

The Department of Health & Social Care's Health Building Note 03-01 (Adult Acute Mental Health) and NHS England's Health Building Note 03-02 (CAMHS) require all fittings – doors, furniture, lighting, sanitary ware – to be ligature-resistant with sloped or tamper-proof fixtures.

CQC guidance from November 2023 on this issue recommends a blend of therapeutic, home-like environments with embedded safety including collapsible rails, concealed fixings, anti-ligature fixtures, well placed sightlines and mirrors/outdoor visibility. Additionally, all mental health inpatient locations must regularly assess and mitigate ligature risks, removing anchor points where possible. Any failure may count as a 'Never Event'.

NHS England also advocates the importance of not relying on environmental solutions alone as a means of reducing the risk of harm. We recognise that the quality of the therapeutic relationship between staff and patients remains the strongest predictor of good clinical outcomes for people receiving inpatient mental health care.

A personalised approached to suicide prevention is essential, ensuring that any environmental adaptations and interventions are part of a comprehensive and co-produced care and treatment plan.

A qualified, well-trained workforce (including mental health and general nurses) is vital, underpinned by competence frameworks for self-harm prevention and active ligature awareness training, including drills and response preparedness.

NHS England has been supporting mental health services to deliver a personalised approach to the risk of harm to self through the introduction of national guidance and a national improvement programme for all NHS commissioned inpatient services; the National Culture of Care Standards and Programme. As part of our National Culture of Care programme, we have commissioned the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) to work with providers to move away from risk stratification tools to personalised safety management. This is to ensure that services are aware of and following the most up to date evidence base for responding to and managing the risk of harm to self.

The North London Mental Health Partnership has conducted a Patient Safety Incident Response Report for this incident and made the following recommendations:

1. All Registered Mental Health Nurses and shift coordinators to continue to implement the shift coordination guidance and handover standards.
2. To ensure staff are aware of compliance with the requirements during prescribed general observation and engagement policy.
3. Share and reiterate the escalation protocol to all staff with emphasis on the expected actions of each staff member.
4. Escalate the concern to the Associate Director of Nursing for physical health for consideration and review of emergency bags.

NHS England will continue to engage with local teams for updates on these recommendations. NLFT advise that that they are compliant with anti-ligature guidance and that all anti-ligature fixtures and fittings are procured from approved suppliers, who are required to design their solutions in accordance with the guidance. They are also a member of the Zero Suicide Alliance and has developed a structured Suicide Prevention Strategy.

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 Louise, 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,

[redacted]

[redacted]
National Medical Director
NHS England