Prevention of Future Deaths Report

Louise Elizabeth Amy Crane (date of death: 19 September 2024)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO: **1) Chief Executive** **North London NHS Foundation Trust** **4th Floor** **East Wing** **St Pancras Hospital** **4 St Pancras Way** **London** **NW1 0PE**
1	**CORONER** I am Ian Potter, assistant coroner for the coroner area of Inner North 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 20 September 2024, an investigation was commenced into the death of Louise Elizabeth Amy Crane, aged 39 years at the time of her death. The investigation concluded at the end of an inquest heard by me between 2 June and 10 June 2025. The inquest concluded with a short-form conclusion of suicide. The medical cause of death was: 1a ligature compression to the neck
4	**CIRCUMSTANCES OF DEATH** Louise Crane had an established diagnosis of Emotionally Unstable Personality Disorder (EUPD). She also had diagnoses of depression and psychosis (in the context of drug use). Ms Crane first came into contact with mental health services in 2012, since then she had been treated in the community, in voluntary in-patient settings, and while detained under the Mental Health Act.

	Ms Crane was admitted to hospital for emergency treatment in relation to her physical health on 2 May 2024, following an attempt to end her life. Once medically fit for discharge, Ms Crane was admitted to an in-patient psychiatric ward at Highgate Mental Health Centre (North London NHS Foundation Trust), under section 2 of the Mental Health Act. This detention commenced on 4 June 2024. Following Ms Crane's initial admission to Highgate Mental Health Centre, she was transferred to a psychiatric intensive care unit (Ruby Ward) on 5 July 2024. Ms Crane remained on Ruby Ward until she was stepped down to an acute mental health ward (Topaz Ward) on 5 September 2024. On 19 September 2024, when Ms Crane remained detained under section 3 of the Mental Health Act, she was found in her room suspended by a dressing gown cord used as a ligature. The jury's findings as to how, when, where and in what circumstances Ms Crane came by her death were, as follows: "Louise Crane died in Highgate Mental Health Centre on 19 September 2024 from a ligature compression to the neck. Factors contributing to Louise's death were a chronic high risk of suicide linked to Emotionally Unstable Personality Disorder, in combination with unsatisfactory information sharing and recording, and inadequate risk management, staffing and levels of care and treatment during Louise's time on Topaz Ward."
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 could occur unless action is taken. In the circumstances, it is my statutory duty to report to you. I acknowledge that the North London NHS Foundation Trust (the Trust) has make progress in addressing some areas of concern the Trust identified during their own internal investigation, and that is to be commended. However, there remain some matters of concern that do not appear to have been addressed and the evidence also revealed other matters that have not been identified in the Trust's improvement plan. The **MATTERS OF CONCERN** are as follows: 1) Record Keeping / Professional Standards There was evidence that staff on Topaz Ward would sometimes use the ID card of another member of staff to makes notes on the records system, without making it clear who the entry was actually made by. In this case there were two entries that appeared to have been made by a support worker, that were actually made by a nurse. Such misleading and inaccurate record keeping risks significant confusion in the provision of care and potentially creates significant risk in relation to the continuity of care.

2) Lack of Professional Curiosity / Therapeutic Engagement – Audits
This was a matter picked up during the Trust's own investigation. The Trust's action plan includes audits to monitor compliance with certain aspects of Trust policy etc. However, the Topaz Ward manager gave evidence that there had been issues with audits in the past, which had been escalated (prior to Ms Crane's death) but no response received. I was not reassured that further audits would be sufficient to address the concerns already identified.

In addition to the above, numerous members of staff from Topaz Ward gave evidence during the inquest and it appeared that many of them struggled with the concept of 'therapeutic engagement'. Some maintained that Ms Crane had received a sufficient level of therapeutic engagement from Ward staff, contrary to the findings of the Trust's own investigation and the subsequent findings of the jury. This suggests a potentially widespread lack of understanding, and underlying knowledge of 'therapeutic engagement' and its importance in mental health care.

3) Step down / discharge from PICU to acute ward
There was evidence that the Trust's systems were unable to accommodate the needs of Ms Crane in ensuring that her transition from an intensive care to an acute setting was as safe as possible for her. Numerous risks and needs were identified for the step down / discharge process, but most of these (which significantly impacted Ms Crane's risk to self) were not facilitated.

4) Therapeutic Engagement / Professional Curiosity – Generally
The jury heard evidence from numerous members of Topaz Ward staff who were taken through the care records, that Ms Crane had become withdrawn from around 12 September 2024 onwards. Many of the witnesses denied this, despite the evidence to the contrary. The fact of Ms Crane becoming withdrawn had been identified by staff in PICU as a significant risk factor for Ms Crane. While this may not have been picked up by all staff due to record keeping issues (already identified by the Trust), the concern here is that there appears to have been a general inability among staff to recognise when a patient is becoming withdrawn, which raises concern about underlying professional curiosity.

5) Observations on Topaz Ward
The Trust's own internal investigation highlighted issues regarding the review of required observation levels. However, the evidence at inquest, in relation to the observation round at or about 11:30 on 19 September raised a further concern, albeit this did not cause / contribute to Ms Crane's death in the particular circumstances.

The evidence was that the support worker conducting this check did not see any part of Ms Crane, and on trying to open the door noted

	there was some resistance. As such, the assumption was made that Ms Crane was sat with her back to the door, and the support worker marked Ms Crane as being in her room and moved on to the next room. This raises the concern that observations being undertaken do not always comply with the Trust's own observation policy and that there may be a staff training / knowledge gap in this regard. 6) <u>Communication and Culture</u> While the Trust's internal investigation highlighted issues with documentation and record keeping, which is key tool for communication, the evidence revealed a lack of general communication between staff at all levels. Aside from documentation matters, a lack of good communication more generally raises significant patient care risks and could undermine patient safety. The substantive consultant psychiatrist for Topaz Ward said that they would change nothing about the care that was provided. This raises concerns that the senior clinician for the Ward does not accept or appreciate the issues identified by the Trust. 7) <u>Trust Action Plan</u> Some of the matters contained within the Trust's action plan, which stems from its own internal investigation, remain outstanding and / or are still awaiting Board level approval. As such, there is, to some extent, a lack of reassurance (at present) regarding the actions that will actually be taken to address the risks the Trust itself has already identified.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you 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 the report, namely by 18 August 2025. I, the coroner, may extend the period. Your response must contain details of actions 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 the following: • Ms Crane's family; and • The Care Quality Commission, for information.

	I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. She may send a copy of this report to any person who she 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 by the Chief Coroner.
9	**Ian Potter** **HM Assistant Coroner, Inner North London** **23 June 2025**