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. **NHS England** **7-8 Wellington Place** **Leeds** **West Yorkshire** **LS1 4AP** 2. **Secretary of State for Health and Social Care** **Department of Health and Social Care** **39 Victoria Street** **London** **SW1H 0EU**
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. The **MATTER OF CONCERN** is as follows: 1) Evidence from a senior member of North London NHS Trust's clinical leadership team revealed that there is a lack of a nationwide policy / approach to anti-ligature measures in mental health settings.
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 18 August 2025. 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 the following: • Ms Crane's family; • North London NHS Foundation Trust. 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**