Prevention of Future Deaths Report

Michael James Crane (date of death: 18 January 2024)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Metropolitan Police Commissioner** **New Scotland Yard** **London** **SW1A 2JL**
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 2 February 2024, an investigation was commenced into the death of Michael James Crane, then aged 54 years. The investigation concluded at the end of an inquest heard by me on 26 September 2024. The inquest concluded with a short narrative conclusion in the following terms: "Drowning in the river Thames, contributed to by the fact that no missing person report had been made to the police." The medical cause of death was: 1a drowning II idiopathic left ventricular hypertrophy related cardiomyopathy
4	**CIRCUMSTANCES OF DEATH** Michael Crane lived in supported accommodation for those living with mental health diagnoses, at Island Place Residential Home (the Home) in Leicester. His past medical history included schizophrenia, complicated by substance misuse, and he was under the care of mental health services in Leicestershire, by virtue of a Community Treatment Order. His schizophrenia was treated with monthly depot injections, the next of which was due on 16 January 2024. Sometime during the afternoon of 15 January 2024, Mr Crane was noted to be 'off Unit' by staff at the Home. He had still not returned home by 23:00 that

	evening. Further checks at 03:00 and 07:00 on 16 January 2024, still noted Mr Crane's absence from the Home. While he was noted to be absent, no action was taken because he was deemed to be 'low risk' and had the freedom to come and go from the Home as he wished. The standard policy at the Home was that they only reported residents missing once they had been unexpectedly absent from the premises for 24-hours. At about 05:54 on 16 January 2024, Mr Crane had self-presented to the Emergency Department at St Thomas' hospital (the Hospital), London, having previously spoken to Metropolitan Police Service (MPS) officers. He was assessed by the Mental Health Liaison Team at the Hospital and there was no indication that he needed to be admitted under the Mental Health Act at that time; the plan was to assist Mr Crane to get back to Leicester so that he could have his depot injection that day, as planned. At about 08:30 on 16 January 2024, the Home received a telephone call from the MPS to advise that Mr Crane had gone to the Hospital. The Mental Health Liaison Team at the Hospital also telephoned the Mental Health services in Leicestershire that were caring for Mr Crane's mental health routinely. Shortly after 11:55 on 16 January 2024, Mr Crane was escorted off-site at the Hospital by a member of staff for the purposes of having a cigarette. However, he left and was seen to board a bus bound for Victoria station. No service had reported Mr Crane missing at this stage. At approximately 16:40 on 16 January 2024, Mr Crane approached two MPS officers on The Strand and asked them if he was a missing person. The officers undertook some checks and advised Mr Crane that he was not a missing person. Mr Crane went with the officers to Charing Cross police station. The officers were aware that Mr Crane had been at the Hospital that morning. They also considered that he was dressed inappropriately for the weather conditions and noted that he was referring to 'hearing voices'. However, they formed the view that he was generally coherent and there were no grounds to detain him under section 136 of the Mental Health Act. One of the officers telephoned the Home, who advised that they had not reported Mr Crane missing but that they intended to do so in about 30 minutes' time. At about 17:30, the officers noted that Mr Crane was becoming more and more anxious to leave the police station and they allowed him to do so. CCTV footage showed that having left Charing Cross police station at about 17:30, Mr Crane spent about 35 minutes in the general vicinity. His whereabouts thereafter are not known. At approximately midday on 18 January 2024, officers from MPS Marine Policing Unit retrieved a body from the river Thames, near Free Trade Wharf.

	The body was identified as being that of Michael Crane, who was still wearing the wristband from his brief admission to the Hospital. At the time of retrieving Mr Crane's body, the Home had not reported him missing. It is not possible to say how, where or when, Mr Crane entered the water.
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) The MPS constable who gave evidence at the inquest, told me that: • if Mr Crane had been reported missing at the time he was in Charing Cross police station then there would have been more that officers could have done to keep him safe; • the fact that officers had heard (directly from staff) that the Home intended to report Mr Crane missing within the next 30 minutes, did not mean that there was more that the officers could have done at the time; and • there was not, either at that time or to date, any MPS guidance to frontline officers in relation to how to approach their powers under section 136 of the Mental Health Act or in relation to people who are likely to be missing but have not yet been reported as such.
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 6 December 2024. 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: • [redacted] – brother of the deceased ([redacted])

	• Prime Life Limited Caernarvon House 121 Knighton Church Road Leicester Leicestershire LE2 3JN ([redacted]) 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** **25 October 2024**