

A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death of a resident at St  
Leonard's Approved Premises, Reading,  
in January 2013**

## ***Our Vision***

*'To be a leading, independent investigatory body,  
a model to others, that makes a significant contribution to  
safer, fairer custody and offender supervision'*

This is the investigation report into the death of a resident at St Leonard's Approved Premises, Reading, who was struck by a train. I offer my condolences to his family and friends.

The man had been a resident at St Leonard's since 26 September, after he had been released on licence from prison. He had lived at St Leonard's on a previous occasion and he settled quickly.

The man's licence expired on 26 December, after which he was no longer required to live at the approved premises, but he had found no suitable accommodation to move to. Although he had been temporarily allowed to stay on at St Leonard's, his predicament was preying on his mind as much of his previous offending was linked with homelessness and misuse of drugs and alcohol. The man had been prescribed antidepressant medication but he often did not take it. On the morning of his death, he left St Leonard's indicating that he was going to the shops. Less than 30 minutes later he stepped in front of a train at Reading West station and was killed.

We consider that staff at St Leonard's could not have predicted the man's actions that morning but, given the deterioration of his mood over previous weeks, he might have benefited from more structured monitoring for those regarded as at risk of self-harm. More could also have been done to encourage the man's compliance with taking his anti-depressant medication and to ensure he had the required support, as part of the offender management process, to secure suitable accommodation.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and others involved in my investigation.

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

**December 2013**

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## SUMMARY

1. On 26 September 2012, the man was released on licence from HMP Bullingdon on licence and that day moved to St Leonard's approved premises in Reading.
2. The man had a long history of public order offences, homelessness and drug and alcohol misuse. However, while he was at St Leonard's he appeared sincere in stating that he wished to address his offending behaviour. One of his key needs was to find accommodation to move to from the approved premises. By the time his licence expired on 26 December, he had not found any accommodation and this caused him a lot of anxiety even though staff at St Leonard's assured him that he would not be evicted.
3. In a long discussion with his offender supervisor on the evening of 25 January, the man reported that he was feeling "low and lost". He said he did not think that some of the people who should be helping him understood his needs and he thought some hoped he would fail. His offender supervisor tried to reassure him that people wanted him to succeed in putting his offending behind him. She was concerned about his mood and asked him if there was a possibility he might harm himself, but the man said that he regretted a previous suicide attempt. The offender supervisor was satisfied that overnight checks were not necessary.
4. On the morning of 26 January, the man signed out of St Leonard's at 11.29am. He wrote in the movement log that he was going to the shops, but less than 30 minutes later he was struck and killed by a train at Reading West station. He had not left behind any letter or note that he intended to take his life.
5. The investigation found that the man's need for accommodation to move on to from the approved premises was not given sufficient priority. The man had not always taken his antidepressant medication as prescribed and staff at the approved premises did not do enough to encourage him to do so. In the days before his death, he reportedly felt low and we consider that there was sufficient concern for staff to have started welfare monitoring.

## THE INVESTIGATION PROCESS

6. Notices announcing the investigation were issued to staff and residents at St Leonard's, inviting anyone who might have information relating to the man's death to contact the investigator.
7. The investigator made a preliminary visit to St Leonard's on 7 March 2013, when he met several of the staff including the area manager. He subsequently returned and interviewed six members of staff and two residents.
8. HM Coroner for Berkshire was informed of our investigation. The Coroner's office provided copies of witness statements about the events at Reading West rail station. A copy of this report has been sent to the Coroner.
9. One of the Ombudsman's family liaison officers contacted the man's brother to inform him about the investigation and to ask if there were any issues he wished to be considered. The man's brother did not identify any specific matters but expected that the investigation and inquest would provide his family with information about what had happened. Having read the draft report, the man's brother said that he had no further comments to make.

## ST LEONARD'S APPROVED PREMISES

10. Approved premises (formerly known as probation and bail hostels) accommodate offenders released from prison on licence and those directed to live there by the courts as a condition of bail. Their purpose is to provide an enhanced level of residential supervision in the community, as well as a supportive and structured environment.
11. St Leonard's is an approved premises in Reading managed by the Thames Valley Probation Trust. It can accommodate up to 22 residents. Staffing at St Leonard's includes managers, offender supervisors (previously known as keyworkers) and support staff, with two staff on duty at night. Residents are required to sign in and out of the premises at all times and all are subject to standard curfew conditions from 11.00pm to 7.00am. During the day, residents are free to go out unaccompanied, although they must state where they are going. (However, the investigator noted there were many times when the man did not sign in as required.) Alcohol and drugs are strictly forbidden but residents can consume alcohol when they are out.
12. Residents are required to attend a morning meeting at 10.00am each day, which is followed by in-house projects on topics such as job hunting, finding accommodation and home domestics.
13. Residents register at one of two local doctors' surgeries. Most prescribed medications are held by premises staff and issued to residents each day. Residents are risk-assessed and allowed to hold medication in their own possession if staff are satisfied that it is safe for them to do so, apart from certain excluded classes of medication which cannot be held by residents. These medicines are always retained by staff and issued to residents according to the prescription. For residents whose risk assessment concludes that they should not retain possession, all of their medicines are retained by staff.
14. The man's death was the third at St Leonard's since the Ombudsman took on the responsibility for the investigation of deaths in custody in April 2004. The first death was in April 2005. That resident also died while away from the premises, but there are no other similarities in the circumstances of that death and of the present one.

## KEY EVENTS

15. The man had a number of criminal convictions dating from 1978 and had served many prison sentences. In March 2012, he was arrested for indecent exposure and use of abusive language and behaviour. He was under the influence of alcohol at the time, as had been the case with much of his previous offending. He was remanded into custody at HMP Bullingdon and later convicted and sentenced to 12 months imprisonment.
16. The man was released on licence from Bullingdon on 26 September 2012. His licence expiry date was 26 December 2012 and his sentence expiry date was 27 March 2013. One of the conditions of the man's licence was that he should reside at St Leonard's approved premises.
17. The man arrived at St Leonard's on the afternoon of his release. The approved premises' administrator met him for an induction and assessment interview. She told the investigator that she was aware that the man had been at St Leonard's in the past and she knew that he had once attempted suicide by jumping from a multi-storey car park. She noted that the man said he had been feeling apprehensive about coming to St Leonard's, but now felt a little better. As a precaution, she arranged for the man to be monitored for possible risk of self-harm for his first days there. (Approved premises have processes for identifying residents who might be at risk of self-harm which includes an action plan to support them.) The man's support plan required him to be checked at two hourly intervals through the night.
18. The man had been prescribed an antidepressant (citalopram) at HMP Bullingdon and arrived at St Leonard's with 19 tablets remaining. The prescription was one tablet per day. This medicine was not on the list of those excluded for own-possession, but the man asked for staff to hold it for him.
19. Residents at approved premises are allocated to a specific offender supervisor, often referred to as a keyworker. The resident is also supported by their external offender manager (probation officer). The man's offender manager was based in Oxford as this was regarded as his home area. Approved premises use an electronic case management system, known as ICMS to record information about residents. On 27 September, the manager of St Leonard's e-mailed the man's offender manager asking for a multidisciplinary meeting to be arranged as soon as possible. She explained that the man:

“... was allocated here on an emergency basis as the Oxford hostel could not take him due to previous allegations of inappropriate behaviour near the hostel ... His links are all in Oxford [and he] will need to be linked in to services here ... With such a short period on licence and [with] his complex needs, move on accommodation needs to be worked on now, and a support network put in place, otherwise [he] will quickly fail here and possibly re-offend quite quickly.”
20. Welfare checks on the man ended on 8 October when the man's offender supervisor noted that he was stable and settled and said that he felt happy.

21. Due to his past mental health history, the man was referred to a community mental health nurse, and their first consultation was on 17 October. The man's offender supervisor noted in the ICMS record that:

“... The man's meeting ... did not go as expected ... [he] became ... angry at the mention of his previous offences and in particular the comment that some were racially aggravated ... If I am in when the man has future appointments ... I will make sure I attend the meeting too [if he agrees] as this may put him at ease ...”
22. The man's records contain no other reference to contact with the community mental health nurse. The man's offender supervisor told the investigator that after the first meeting her understanding had been the community mental health nurse intended to work from previous reports and assessments in developing his own reports on the man and that he would not have too much direct contact with the man. The man's offender supervisor added that this arrangement had suited the man at the time.
23. On 9 November, the man's offender supervisor e-mailed the offender manager to invite her to a meeting at St Leonard's to discuss the man's 'move-on' needs. (The man's place at St Leonard's was guaranteed only to 26 December, when he would no longer be subject to licence conditions.) The offender manager telephoned three days later to say that she would not be able to arrange a meeting for the next two weeks. The offender supervisor noted in ICMS that the man had no links with Reading so it would not be possible for him to apply for accommodation through Reading Borough Council.
24. Over the next few days, the offender supervisor contacted Reading and Oxford councils to find out if they could collaborate to help the man with housing. It seems that neither council was of much assistance but the man said that he hoped to have saved over £1,000 by Christmas for a deposit on a private flat.
25. On 26 November, the man's offender supervisor advised him to go into town to find out about landlords who accepted tenants on housing benefit. She said that she would be able to issue an eviction notice which usually helped put pressure on the council in finding accommodation. She noted that there were no problems with the man's "health and emotional well-being".
26. Entries in the man's ICMS record over the following weeks show that he was still having no success in finding accommodation. On 26 December, his licence expired, which meant that he would usually be expected to move out of St Leonard's. The offender supervisor had e-mailed the offender manager the day before to say:

“... Strictly speaking [the man] should be evicted ... However, we have as yet not had any luck finding him suitable move on accommodation. [He] has saved up enough money to fund his own deposit and has been ... looking at flats but we are struggling to find him somewhere ... which accepts housing benefit ... I was wondering if it would be possible to extend his place [here] for a couple of weeks into the New Year?”

The offender manager replied to say she agreed to an extension.

27. The offender supervisor made an ICMS entry on 12 January, about a keywork session with the man which centred on a search for private accommodation. She had had no success with this but advised the man to keep enquiring with estate agents. She noted that he still seemed emotionally stable, although he admitted feeling anxious about finding accommodation as he recognised that being homeless might trigger deterioration in his behaviour.
28. On 22 January, the offender supervisor went to update the man on progress with finding him accommodation. She told the investigator that the man usually watched the television in the lounge with other residents but that evening he was alone in his room. She described him as not his usual self. He said that he did not want to be a burden to staff so she took him to the office to try to reassure him that this was not the case and that the staff were committed to finding him appropriate accommodation. She also spoke to him about arranging a GP appointment as his antidepressant medication was running low and to discuss the possibility of taking analgesics as he had suffered with leg pain during the cold weather. She told the man that they would have a formal keywork session on Friday evening (25 January). The offender supervisor made an entry in the ICMS record which indicated that she had considered whether he might be at risk to himself:
- “Despite [his] emotional concerns I have decided not to put [him] on welfare checks as I do not feel he is at imminent risk of harming himself. I have informed him if he feels depressed ... to speak to staff at once ...”
29. Another offender supervisor at St Leonard’s, told the investigator that although she was not the man’s key-worker she had enjoyed talking with him as they shared a similar taste in music. She was aware of the difficulties the man was having in finding accommodation and that this was making him anxious. She said he became quiet and was very low in mood in his final weeks. On the afternoon of 23 January, she learned that he had gone to the GP for some more antidepressants, but the GP had not prescribed any. She telephoned the GP surgery and was told that, as the man had not been taking his medication as instructed, he would need to have a full medication review. (The man’s citalopram prescription was for him to take one tablet each day, but on average he took a tablet only once in three days. For citalopram to be fully effective it needs to be taken as prescribed.) A medication review with the GP was arranged for the following Monday, 28 January.
30. The Area Manager said that because there had been problems with continuity of management at St Leonard’s caused by sickness and other reasons he had visited on the afternoon on 23 January. He said he did not have time that day to check on the progress of all the residents but asked the staff if there were particular concerns. The staff told him about the difficulties finding accommodation for the man. He checked the man’s records and considered that progress had stalled. He thought the man’s offender supervisor had done a lot of work but that she was new and too junior to progress matters with external agencies. He said he planned to discuss the man’s case at the next multi-agency meeting on 1 February.
31. The investigator asked the Area Manager about what support the offender supervisor might have expected to receive from the man’s offender manager. He said that Thames Valley Probation Trust has guidelines setting out the

expectations of offender managers and approved premises staff for managing residents. The guidance was clear that the responsibility for progressing and developing move-on plans lay with the offender manager who must be actively engaged from the time the resident arrived.

32. As they had agreed earlier in the week, the offender supervisor met the man for a keywork session on the evening of 25 January. She made a lengthy ICMS entry which included:

“[The man] reported feeling [as] low and “lost” as he did on Tuesday ... did not feel other agencies and some staff were understanding of his needs and ... assumed ... he could do more for himself that he is actually able to. An example [was] how he felt treated by the GP surgery ... After [going] to get repeat Citalopram ... and pain killers ... he felt turned away ... because they would not issue him with anything there and then ... I reiterated ... that ... he did the right thing by going as he ... now has an appointment [on 28 January] to get his medication sorted ... the man ... mentioned that he felt certain people were looking for him to trip up and fail as all they look at are his past crimes ... I assured him that ... reports like the ones [community health] ... write have to look into ... previous offences as the past shapes [the] present ... I [added] that ... staff are 100% behind [him] and are willing him to succeed ... I asked him if he felt at risk of self-harm ... He said he regretted [previously] jumping from the car park roof and ashamed of the fact that if he had succeeded, someone would have had to “find him” and he would have “left behind people who would be upset”. I was satisfied that despite his low mood, he would not require welfare checks ... He stated he had spoken on the phone with his mother today and was going to write to her during the week ... I finished ... by [telling] him ... to remain positive and [to speak] to staff if he feels he needs to.”

33. When interviewed by the investigator, the offender supervisors spoke about the man’s problems finding accommodation. She said that Reading Borough Council had not assisted, but the man had saved enough to allow him to rent privately so he then had to find a landlord who accepted housing benefits. The man was fearful, however, that if he found private rented accommodation, he would be left without social support and interaction. She told him that at the multi-agency meeting to be held the next week she would press for some form of supported accommodation or at the very least, shared accommodation linked in with an external worker to help with day-to-day activities if needed. She thought that the man had understood what she had told him.
34. The offender supervisor explained further her decision not to set up welfare checks on 25 January. She said that she had specifically asked the man about suicidal intentions and he had seemed very sincere when speaking about not wanting others to deal with finding a dead body. She did not believe that his mood would have been helped by having staff check him during the night.
35. The investigator asked the offender supervisor about the man’s antidepressant medication as, although he was prescribed one a day, he had collected only six tablets in the first 25 days of January. She said that she had spoken to the man about this but he had said that his depression was mainly caused by misuse of drugs and alcohol and, while he was not using alcohol or drugs, he

felt fine. He said he felt safe at St Leonard's so he did not need much medication. She said that he had been cheery when he first arrived so it had not been seen as a priority at that time to try to ensure he took his medication. When his mood lowered, arrangements were made for him to see his GP.

36. A relief offender supervisor was working at St Leonard's on 26 January. At a handover briefing, the offender supervisor had explained to her that the man was finding it frustrating that no accommodation for him to move to had been found. The relief offender supervisor did not speak to the man that morning but she saw him sitting in the lounge. Another relief offender supervisor was also working that day. He told the investigator that he and the man had a good relationship and exchanged jokes. He said that the man had seemed his usual self on the morning of 26 January, with no apparent cause for concern.
37. Two residents who were friendly with the man at St Leonard's, both told the investigator that the man had become more withdrawn and dejected in his final weeks due to his worries about finding accommodation. The man did not mention having any thoughts of self-harm to them and neither suspected that he might harm himself.
38. The man signed out of the premises at 11.29am on the morning of 26 January and wrote in the log that he was going to the shops. Less than 30 minutes later he was struck and killed by a train at Reading West station. In a statement to the police, the train driver wrote that he had noticed a man standing on the station platform who then dived to the track with the train just ten feet away and travelling at around 50 miles per hour. The driver wrote that the man had not tripped or stumbled and it had seemed a deliberate act.
39. Police officers informed the man's family and the staff at St Leonard's of his death. He had left no note behind to explain his actions. The Probation Trust subsequently contacted his family to offer condolences and assistance with the funeral expenses.

## ISSUES

### Accommodation support

40. The man's licence expired on 26 December, when he was no longer required to live at the approved premises. He would ordinarily have moved to other accommodation at that stage but had been unable to find suitable accommodation. He had been allowed to remain at St Leonard's temporarily. The man was understandably very concerned about the possibility of becoming homeless, which he thought would trigger him to return to alcohol and drug misuse and further criminal offences. Although staff at St Leonard's had tried to reassure him that he would not be evicted, it is clear that he remained worried about the position, particularly as he still had no potential accommodation a month after his licence had expired.
41. Efforts to find new accommodation for the man were hampered by his lack of ties to Reading. As he was regarded as a resident of Oxford, Reading council would not assist him. The man's offender supervisor explored the possibility of some collaboration between Reading and Oxford Councils but nothing came of it. The man had some savings so he was looking for private rented accommodation as an alternative and she was helping him with this search.
42. The offender supervisor said that she would have hoped to have had more support and assistance from the man's offender manager who was based in Oxford. The Area Manager agreed and said that the Probation Trust sets out expectations and responsibilities of various staff for developing and progressing move-on plans and that planning should start at the earliest point after a new resident arrives. This did not seem to have progressed satisfactorily with the man and seems to have contributed to his anxiety. We make the following recommendation:

**The Probation Trust should ensure that offender managers appropriately prioritise support for residents needing help finding accommodation to move on from approved premises.**

### Assessment of risk

43. When the man first arrived at St Leonard's, he was subject to welfare monitoring checks for 11 days, as a precautionary measure because of his past history of self-harm. This appears to have been a reasonable decision.
44. It is clear that the man settled quickly and staff had no further concerns about him until the two weeks before his death. The evidence from staff and other residents was that there was a clear deterioration in his mood at that point. On 25 January, the offender supervisor made an ICMS entry that he was feeling very low and had also felt that way on 22 January. As well as being anxious about potential homelessness, the man feared having to move to private accommodation without any form of structured social support. The offender supervisor told the man that she would try to find him accommodation with some form of support. She explored with him whether he had any suicidal thoughts and she felt reassured by his response. It is clear from the length and detail of her ICMS entry that she had thought very carefully about the man's presentation before reaching her decision.

45. By this time, the offender supervisors had known the man for four months and was the member of staff best placed to decide whether welfare checks were needed. She decided, on balance, that they were not. She told the investigator that the man had been very convincing that he would not do anything to harm himself. She said that she could have telephoned the on-call manager for a second opinion, but thought the advice would probably have been that as she knew the man best, she was the best person to make the decision.
46. Welfare monitoring would not have prevented the man from leaving the premises unaccompanied, as happened on the morning of 26 January, and we make no criticism of the individual decision. We do not consider it would have been possible for the staff at St Leonard's to have predicted or prevented his actions that morning. However, the welfare check process includes devising an action plan to support the resident through a period of crisis. The resident is actively involved in constructing and achieving the plan. It is possible that involving the man in such a plan might have helped him overcome this period of crisis. On balance, we consider that starting welfare monitoring would have been the prudent option in view of his apparent low mood at that time and we consider that welfare monitoring should usually be instigated when there are reasons to consider a resident is feeling low.

**The Probation Trust should ensure that approved premises staff begin welfare monitoring and implement a supportive action plan whenever there are significant concerns about the wellbeing of a resident.**

## **Medication**

47. The man arrived at St Leonard's with 19 tablets of citalopram, an antidepressant, to be taken one per day. Citalopram was a medicine that residents at St Leonard's were allowed to retain in possession but the man asked staff to hold it for him. He subsequently obtained one repeat prescription of 28 tablets from the GP practice he was registered with.
48. The man did not take his medication consistently. On average he took one citalopram tablet every three days and there were times when he did not take any for a number of days. The offender supervisor said that, although she reminded the man about this, his approach was to take medication only when he felt he needed it. She said that for much of the time that she knew him, he was settled and enjoying being at St Leonard's, although his mood declined towards the end. Other staff and residents also noticed this decline in mood.
49. Pharmaceutical advice to patients prescribed citalopram is that it can take between two to four weeks for the benefits of the medicine to appear and so it is important that they keep taking it consistently.
50. Staff at approved premises are not able to require residents to take medication and the man had the capacity to decide himself whether he took his medication. However, we consider that staff should have made more active attempts to persuade the man to take his medication in line with his prescription. They could have reminded him about the manufacturer's advice on how citalopram should be taken and asked the community mental health nurse to advise the man about the importance of taking his medication as prescribed.

**The Probation Trust should ensure that approved premises staff actively encourage residents to take their medication as required.**

## **RECOMMENDATIONS**

1. The Probation Trust should ensure that offender managers appropriately prioritise support for residents needing help finding accommodation to move on from approved premises.
2. The Probation Trust should ensure that approved premises staff begin welfare monitoring and implement a supportive action plan whenever there are significant concerns about the wellbeing of a resident.
3. The Probation Trust should ensure that approved premises staff actively encourage residents to take their medication as required.

**ACTION PLAN:**

<b>No</b>	<b>Recommendation</b>	<b>Accepted/Not accepted</b>	<b>Response</b>	<b>Target date for completion</b>	<b>Progress (to be updated after 6 months)</b>
1	The Probation Trust should ensure that offender managers appropriately prioritise support for residents needing help finding accommodation to move on from approved premises.	Accepted	The offender manager concerned has moved on but TVPT will promote the recommendation as a general learning point.	Ongoing (to reach OMs who are fresh to working with AP residents)	n/a
2	The Probation Trust should ensure that approved premises staff begin welfare monitoring and implement a supportive action plan whenever there are significant concerns about the wellbeing of a resident.	Accepted	However, we note that the report does not in fact identify any errors in the AP staff's conclusion that there were no significant concerns about The man's wellbeing and that he did not require welfare checks. TVPT staff would have set up an action plan had the need for one been identified.	Ongoing	n/a
3	The Probation Trust should ensure that approved premises staff actively encourage residents to take their medication as required.	Accepted	Under the medication in possession policy, AP residents holding their own medication are entirely responsible for taking it as prescribed. Staff have no way of knowing whether this has happened. Encouragement as envisaged in the recommendation would therefore have little effect and could not practically be followed up. However, where medication is held by staff and issued to residents, the scope for noting when a resident has not kept up with their dosage is much greater. TVPT will ensure that greater efforts are made to press residents to take their medication when this happens.	Ongoing	n/a