Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Steven Ison, a prisoner at Bowling Green Approved Premises, on 13 May 2025

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

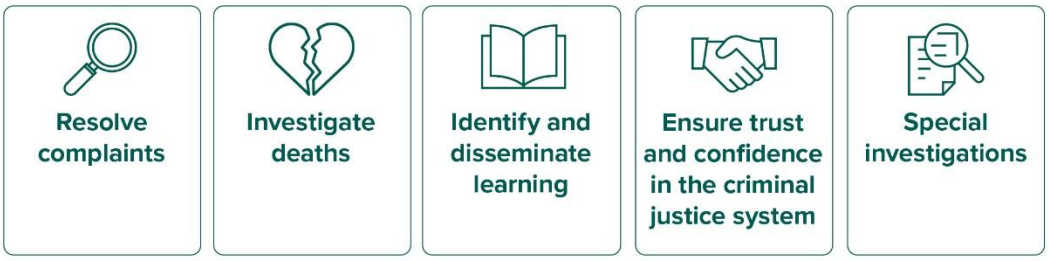
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Steven Ison was found dead in his room on 13 May 2025, while a resident at Bowling Green Approved Premises. He had taken his own life by placing a plastic bag over his head secured with a ligature. He was 59 years old. I offer my condolences to Mr Ison's family and friends.

While Mr Ison had a history of poor mental health and alcohol use he did not have a history of suicide attempts or self-harm and there had been no concerns about him while he was in prison or while he was a resident at the approved premises.

Mr Ison was unhappy to have been placed at Bowling Green, because it was far away from his family. While it is evident that Mr Ison was suffering with anxiety and that staff were aware of this, at no point did staff believe that he was intending to harm himself or end his life and when asked he had denied that he had any such intention. I am, however, concerned that a review of his support and safety plan was not carried out when his anxiety noticeably increased.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Adrian Usher
Prisons and Probation Ombudsman **February 2026**

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Summary

Events

1. On 30 August 2024, Mr Steven Ison was remanded into custody. He was later found guilty of assault of his former partner and he was given an eighteen-month sentence.

2. On 20 March 2025, a prison offender manager completed Mr Ison's initial custody OASys (a tool used by staff to assess the risks and needs of the offender). They concluded that Mr Ison posed a medium risk of harm to the public and known adults. Mr Ison did not have a recent history of suicide attempts or self-harm.

3. On 10 April, the community offender manager completed Mr Ison's pre-release OASys. She concluded that Mr Ison posed a high risk of harm to known adults and as a result he should live in an approved premises (AP) on his release.

4. On 16 April, Mr Ison was released on licence from HMP Kirkham to Bowling Green Approved Premises.

5. During Mr Ison's induction, AP staff assessed his risk of suicide and self-harm. They did not identify any immediate concerns. Mr Ison said that he had self-harmed in the community on one occasion three years previously.

6. On 13 May, Mr Ison was anxious and agitated during the early hours of the morning. One of the residential workers supported him for several hours and referred him to the NHS Mental Health Crisis Team (MHCT).

7. Around 9.00am, Mr Ison spoke to someone in the MHCT, after which he returned to his room.

8. At approximately 11.04am, a residential worker went to Mr Ison's room to carry out a welfare check and found Mr Ison on his bed with a bag over his head secured by a ligature.

Findings

9. We are satisfied that both AP and probation staff responded to Mr Ison's concerns about being in an AP that was not close to his family.

10. However, there were two occasions when Mr Ison's anxiety increased significantly. These should have triggered an urgent review of his Support and Safety plan.

11. Mr Ison was prescribed mirtazapine and when he was released from prison he was not given an adequate supply. This issue was not sufficiently prioritised when he arrived at the AP and we believe more could have been done to prevent Mr Ison running out of his medications.

Recommendations

- The Approved Premises Manager should:
  - remind staff to take account of the quantity of medicines that they hold and alert a resident when a medication is running low; and
  - record any conversations or actions they take either on the medication administration record or the resident's personal record.
- The Approved Premises Area Manager, North-West, should ensure that Bowling Green staff are clear about the requirement to review the SASP when there has been a significant event.

The Investigation Process

12. HMPPS notified us of Mr Ison's death on 13 May 2025.

13. A PPO investigator issued notices to staff and prisoners at Bowling Green Approved Premises informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

14. The investigator obtained copies of relevant extracts from Mr Ison's prison and probation records along with his medical records. She also obtained information from the police who attended as part of the emergency response, as well as Mr Ison's GP.

15. The investigator interviewed three members of probation staff on 21 July and 6 August. She and another PPO investigator interviewed six members of staff at Bowling Green on 7 August.

16. We informed HM Coroner for Cumbria of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

17. The Ombudsman's office contacted Mr Ison's son to explain the investigation and to ask if he had any matters he wanted us to consider. Mr Ison's son wanted to know why his father had been sent to an AP in Carlisle, which was a considerable distance from his family. He also asked why his father had been told that he was not able to have any contact with his grandchildren. We have addressed the latter point in separate correspondence.

18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

19. Mr Ison's son received a copy of the draft report. He did not make any comments.

Background Information

Bowling Green Approved Premises (AP)

20. APs (formerly known as probation and bail hostels) provide an enhanced level of residential supervision in the community for prisoners who have been assessed as posing a high risk of harm. Referrals for an AP are made by probation officers to the Central Referral Unit (CRU). If the prisoner is eligible the CRU identify where there are available bed spaces and they send the referral on to the AP for the manager to consider whether they are suitable.

21. The National Probation Service, North-West Area, manages Bowling Green AP in Carlisle. Residents must be aged over 18. Most residents are required to stay as a condition of a court order or release licence.

22. During induction, staff tell residents about the premises' rules and allocate them a key worker who is their primary contact and who holds one-to-one sessions about the issues in the offender's sentence plan. Residents are responsible for their own health and are required to register at a GP surgery.

23. When residents arrive, staff complete a risk assessment to determine whether they will hold their own medications or whether staff will store and administer them under supervision. Residents must sign a medication contract outlining their responsibilities

24. In line with the Safety and Support Plan (SASP) guidance, staff create a Safety and Support Plan for every resident to identify any risks or triggers that could affect their emotional wellbeing and to help manage any risks of suicide or self-harm. Staff are required to review the plan within 14 days or after a significant event.

25. Staff carry out four welfare checks and must have at least two meaningful conversations with each resident every day. Each welfare check requires a roused response, either verbal or physical. The meaningful conversations can be informal and cover any topic, so long as they allow staff to assess the resident's mood.

Previous deaths at Bowling Green AP

26. In June 2024, a resident of Bowling Green took his own life while away from the AP. The resident had some risk factors that indicated he was at risk of suicide and self-harm. We were satisfied that AP staff had appropriately managed his risk.

Temporary Presumptive Re-categorisation Scheme (TPRS)

27. TPRS is an urgent measure introduced in March 2023 by the Government to make the best use of the prison estate. It allows for the re-categorisation of prisoners (who meet the eligibility criteria) from category C to category D, which in turn means that they can move to an open prison. To support this scheme operational guidance was provided to relevant staff to guide them through the assessment process. The guidance stated that in certain cases, a light-touch start custody OASys was all that was required rather than the standard full assessment.

Key Events

28. Mr Steven Ison had a history of domestic abuse and harassment towards his former partner.

29. On 30 August 2024, Mr Ison was remanded into custody and sent to HMP Altcourse.

30. During the second healthcare assessment Mr Ison told staff that he had suffered from poor mental health and had been diagnosed with post-traumatic stress disorder (PTSD), depression and Tourettes (a neurological disorder that causes tics – sudden movements or sounds). He said that he had self-harmed once a few years previously, and he had problems with excessive alcohol consumption.

31. On 10 February 2025, Mr Ison was sentenced to 18 months in prison for malicious wounding of his former partner, and other offences.

32. On 20 March, a Prison Offender Manager (POM) completed a start- custody OASys report for Mr Ison. In interview, the POM told the investigator that Mr Ison was identified as potentially eligible for the Temporary Presumptive Re-categorisation Scheme (TPRS) and in line with the guidance he completed a light-touch OASys. He said that the assessment included an interview with Mr Ison and a partial review of his custodial and criminal records. He concluded that Mr Ison posed a medium risk of harm to known adults (due to his history of domestic abuse of his partner) and as a result he would not require an AP placement on release.

33. On 21 March, Mr Ison was transferred to HMP Kirkham, a category D prison. His prescription for mirtazapine (an antidepressant which also helps with sleep) was re-issued and he was given a 28-day supply.

34. On 3 April, a Probation Officer and a POM met with Mr Ison to discuss his imminent release. During the meeting, the probation officer explained to Mr Ison about the restraining order, which stipulated that he was not to have any contact with his former partner. Mr Ison told her that his mental health was stable.

35. On 10 April, the probation officer completed the pre-release OASys and concluded that Mr Ison was a high risk to known adults. In interview, the probation officer told the investigator that, as part of her assessment, she had carried out additional checks which included contacting the police. She said that unlike the start custody OASys, she was assessing information with a view to his imminent release. Based on the information provided by the police the probation officer decided that Mr Ison should be classified as a high risk of harm.

36. On 11 April, Mr Ison was allocated a Community Offender Manager (COM). Because he was considered to present a high risk of harm to known adults, the COM completed an emergency application for an AP (because he was due to be released within 28 days) and sent this to the CRU. The COM recorded that Mr Ison preferred to live in Chester (or within 60 miles of it). The CRU reviewed the application the same day and a placement was automatically requested.

37. A CRU Manager told the investigator that because prisoners are not released on a Friday, bank holiday or weekend, prisoners with a release date between 18 and 21

April 2025 (the Easter bank holiday weekend) were all being released on 16 April. This made it more difficult for the CRU to accommodate all those who needed a bed, and for the placement to be in their preferred location.

38. On 14 April, a placement for Mr Ison was booked at Bunbury House AP, about eight miles from Chester. However, the Area Manager for Bunbury House subsequently contacted the CRU to say that they had no spaces.

39. Later that day a placement was booked at Linden Bank AP (Crewe). A short while later Linden Bank contacted the CRU to say they too had no spaces. (The CRU Manager said that he checked the occupancy spreadsheet and there had been an error in recording of available spaces.)

40. On 15 April, the CRU Manager asked a member of the team to book a placement at Highfield House AP (Blackburn). At the time, he was unaware that a colleague had already arranged a placement at Bowling Green. Given that the placement had been secured a decision was made to not proceed with a placement at Highfield House.

41. On the same day, a prison offender manager met with Mr Ison to go through his licence agreement. They recorded in his probation record that Mr Ison said he would not be going to Bowling Green and he refused to sign his licence agreement.

42. On 16 April, Mr Ison was released on licence from Kirkham to Bowling Green. His licence conditions included a restriction on any communication with his former partner.

43. A residential worker at the AP completed Mr Ison's induction. The residential worker told the investigator that Mr Ison came across as quite nervous and anxious. As part of the induction, the residential worker completed the Support and Safety Plan (SASP) Guided Welfare Assessment. (This is a tool used by AP staff to explore a person's risks and triggers for suicide and self-harm so that an appropriate support plan can be put in place.)

44. Mr Ison told the residential worker that he was okay with being at the AP and rated his mood as seven out of ten. He said that he had previously used drugs and alcohol and that he did not have any physical or mental health concerns. Mr Ison said that he had self-harmed once three years previously. Based on his responses the residential worker concluded that Mr Ison only required standard welfare checks.

45. Mr Ison told the residential worker what medications he was taking. The AP were unable to find a copy of Mr Ison's medicines in-possession risk assessment, but they told the investigator that Mr Ison had been assessed as not suitable to hold his own medications. It was recorded by staff on the medication administration record that he only had a four-day supply of mirtazapine. Staff completed a GP registration form on Mr Ison's behalf.

46. The investigator made enquiries with the clinical team at HMP Kirkham about medications for prisoners being released. They said that that medications are supplied on discharge and ideally it would be a one-month supply (due to delays in people registering with a GP). The clinical team could not provide any information

specific to Mr Ison's medications as they said they no longer had access to his medical records.

47. Later that day, the AP Manager reviewed the SASP along with Mr Ison's OASys and prison records. He noted that Mr Ison had a history of using alcohol and valium (a prescribed drug used to treat anxiety) so he changed Mr Ison's welfare checks to six and one recorded meaningful conversation per day.

48. On 17 April, the residential worker carried out the second stage induction. He recorded that Mr Ison had settled in well.

49. Later that day, a probation officer met with Mr Ison via video link. She recorded that Mr Ison was frustrated that he was in an AP far away from his family and that he felt isolated.

50. On 21 April, Mr Ison was unable to take his mirtazapine medication as it had run out.

51. On 22 April, a key worker met with Mr Ison and completed his support plan (a document for staff to help them understand the individual, what their risk factors are, and how to support them). Mr Ison identified that alcohol was a risk factor for him, and that others could help him by trying to get his medication sorted and his sick note to allow him to claim benefits. The key worker updated his probation record with their discussion. She recorded that Mr Ison had run out of his medication and that he had said his anxiety was "through the roof" because he was in Carlisle.

52. In interview, the key worker told the investigator that even though Mr Ison had said he was very anxious, he had not come across as such. She said that he was very focused on moving to be closer to his brother and it had been difficult to move the conversation away from this topic. Following the meeting with Mr Ison, the key worker sent forms to the local GP practice to register Mr Ison, she requested a sick note on his behalf and emailed Mr Ison's COM to alert her to his anxiety.

53. On 23 April, the key worker contacted the GP surgery about Mr Ison's medication. They advised her that they had contacted the prison for further information. Later that day a new prescription for seven days was issued by the GP and Mr Ison recommenced taking his mirtazapine.

54. On 25 April, the COM met with Mr Ison via video link. She recorded that Mr Ison said he wanted to be nearer to his family. The COM told Mr Ison she would explore facilitating a transfer and reducing his placement in the AP from twelve to eight weeks.

55. Following the meeting the COM emailed the CRU and the key worker. She said that she was worried about Mr Ison's mental health. He had complained that he was not sleeping, had no appetite and suffered with PTSD, anxiety and depression. The COM asked if there was any scope to move Mr Ison to another North-West AP closer to his family.

56. The CRU Manager told the investigator that he forwarded the COM's email to the AP Manager. He said that the decision to agree a transfer, along with the responsibility for finding an AP with a vacancy, sat with the AP Manager.

57. Later that day the AP Manager responded to the COM saying that Mr Ison was eating every day. In interview the AP Manager told the investigator that he had checked with the catering manager who had said that Mr Ison came down every day to eat.

58. On 29 April, the key worker updated Mr Ison's probation record to say that she had completed his SASP review. She said she had no concerns.

59. It is recorded in Mr Ison's GP record that his medicine prescriptions were on a weekly repeat cycle and Mr Ison's medication administration record showed that he had received a seven-day supply of mirtazapine. (However, while the prescription was on a repeat cycle it did not automatically lead to a prescription being created as the AP later had to contact the GP again when Mr Ison's medication ran out.)

60. On 1 May, the COM asked the AP Manager if an alternative AP had been found. The AP Manager replied saying that it was not a priority. He explained that another AP had closed and they were under high levels of demand.

61. In interview the AP Manager told the investigator that at that time Bowling Green was full and so were the other APs in the area. The AP Manager said that he was aware that Mr Ison was anxious but thought he was okay. He said that due to its location, most residents placed at Bowling Green were not from the local area and would rather be somewhere else and he was not able to act every time someone wanted to move.

62. On 2 May, the COM and the probation officer met with Mr Ison via video link. The COM noted that Mr Ison was depressed about being so far away from home and he was encouraged to speak to his GP. She told him that there were no beds available anywhere else and she was still exploring his placement being reduced.

63. On 8 May, Mr Ison did not take his mirtazapine as it had run out. One of the AP staff recorded that Mr Ison had mentioned his medications a few times to different staff who were chasing it up. The key worker was notified and she sent an email to the GP surgery asking for a repeat prescription to be issued. She did not record this action on his record.

64. On 8 May, the COM met with Mr Ison via video link. She told him that she was happy to reduce the placement to eight weeks and that she would apply for him to be housed in temporary accommodation closer to home. She noted that he was happy with this.

65. On 9 May, the key worker met with Mr Ison as part of his weekly key work sessions. She recorded that Mr Ison had said that he still did not want to be at Bowling Green but he was feeling less anxious. He said he had been without his mirtazapine for three nights and had not been sleeping but he was expecting a new prescription that day. Mr Ison recommenced his mirtazapine that evening and was given a seven-day supply.

66. The same day the medication administration record for Mr Ison's other medications was annotated "returned to chemist". No explanation was provided as to why this was recorded on the form or in his core record.

67. At approximately 2.30am on 11 May, Mr Ison went to the AP office and spoke to a Probation Services Officer. He asked her to call the police as he wanted to tell them about an alleged offence he had carried out against his former partner the previous year. She noted that he was anxious and worried. A few hours later Mr Ison spoke to the probation services officer again and said that he may have imagined the offence and did not want to speak to the police.

68. The probation services officer told the investigator that she was concerned about Mr Ison's mental health and she offered Mr Ison a call with the Mental Health Crisis Team and the out of hours manager but he declined both. The probation services officer said she also asked Mr Ison if he wanted to bring down his bedding to the lounge where she could provide him with company and offered him some food, but he declined this saying he wanted to return to his room to speak to his son. The probation services officer said that she carried out two further checks on him during the early hours of the morning.

69. At 10.10am, a residential worker updated Mr Ison's record. He noted that Mr Ison had spoken to the police who told him that they were going to investigate his claim. The police would also be making a mental health referral.

70. At 6.57pm on 12 May, a residential worker updated Mr Ison's record. He recorded that Mr Ison had been much better that day. While he had been a bit hyperactive in the morning he had calmed down in the afternoon.

Events of 13 May

71. At approximately 1.20am, Mr Ison asked a residential worker to call the police as he wanted to report a crime. In interview, the residential worker told the investigator that he invited Mr Ison to sit with him in the lounge. He said that Mr Ison spoke to him about several things and as the conversation went on Mr Ison had become calmer and more relaxed. The residential worker said that he spent around three hours with Mr Ison after which Mr Ison returned to his room. The residential worker updated Mr Ison's records and wrote that at no point had Mr Ison expressed any suicidal ideation or thoughts of self-harm. The residential worker also sent a detailed email to the AP Manager and the COM at 6.00am, explaining what had taken place.

72. The residential worker said that a while later a resident alerted him to Mr Ison needing to see him. He said that Mr Ison appeared even more anxious and had developed a facial tic. Mr Ison told the residential worker that he was worried that he would report their conversation and that he may have got his son into trouble.

73. At 7.27am, the residential worker phoned the MHCT and told them that Mr Ison needed to be seen urgently.

74. At 9.05am, the AP Manager updated the record to say that he had spoken to the COM and asked that she contact Mr Ison today.

75. In interview, a residential worker told the investigator that the MHCT phoned the AP and she arranged for Mr Ison to take the call in a private room. She said that she provided the MHCT with a contact number so that they could speak to AP staff following the call with Mr Ison if necessary but they did not call to update AP staff.

She said that she observed Mr Ison on the phone and that he had appeared calm. She said that the call ended at around 9.05am and when Mr Ison left the room she asked him about the conversation, but he did not share any information. The residential worker told him that they were arranging a call with his probation officer for later that day.

76. At 9.45am, the COM acknowledged the residential worker's email. She arranged a time to speak to Mr Ison in the afternoon and for a mental health practitioner to join the meeting to assess Mr Ison.

77. At approximately 11.04am, a residential worker went to Mr Ison's room to carry out a welfare check. In her statement the residential worker said that she knocked on his door and when there was no answer she unlocked the door and entered the room. She said that Mr Ison was lying on his bed with a plastic bag over his head, secured in place by a black strap. The residential worker said she used her shark knife (a special tool to remove ligatures) to cut the strap and then she removed the bag. The residential worker said that she checked for a pulse and breathing but there were no signs of life. She then activated her alarm and called for an ambulance.

78. Another residential worker said she was first to respond to the alarm. She said when she arrived the bag had been removed and Mr Ison was on the bed not breathing. She said she used her alarm and she went to collect the defibrillator, passing her colleague, a probation services officer, who was also responding to the alarm.

79. The residential worker returned to the room and along with the probation service officer they moved Mr Ison to the floor where the probation services officer began CPR. They also applied the defibrillator, which did not give any shocks.

80. At 11.09am paramedics arrived and took over attempts to revive Mr Ison. They declared life extinct at 11.35am.

Contact with Mr Ison's family

81. The police informed Mr Ison's family of his death. The AP Manager spoke to Mr Ison's next of kin and sent a letter of condolence the next day which included details about the financial assistance for funeral costs, in line with policy. He subsequently arranged for Mr Ison's property to be returned to the family.

Support for prisoners and staff

82. After being notified of Mr Ison's death, the AP Manager travelled to Bowling Green to provide support and assistance to staff and other residents. All staff were told about the support that was available to them.

83. Mr Ison's probation officers also confirmed that support was offered to them following the notification of Mr Ison's death.

Post-mortem report

84. The post-mortem report gave Mr Ison's death as asphyxia caused by a plastic bag and ligature. The toxicology report identified the presence of mirtazapine, consistent with a therapeutic dose and Naloxone, which is commonly administered during emergency medical treatment.

Record of Inquest

85. The inquest into Mr Ison's death was held on 6 February 2026 and a verdict of suicide was recorded. The coroner concluded that Mr Ison's death was due to asphyxia caused by a plastic bag and ligature.

Findings

Decision to send Mr Ison to Bowling Green Approved Premises

86. Mr Ison was identified as posing a high risk of harm on release and therefore requiring a placement in an AP six days before his release. The TPRS guidance directs probation officers to undertake a light-touch OASys at the beginning of the custodial period and it is therefore understandable why the initial decision about his risk was different to that reached by the probation officer when she came to complete the pre-release OASys.

87. The outcome of this change so close to his release was understandably upsetting for Mr Ison and his family and it also reduced the amount of time that the CRU had to try and find an AP placement for him. However, given that the number of people requiring a placement and the availability of spaces is dynamic and can change from day to day, on balance we do not believe that the short-notice application was the reason why an AP closer to his preferred location could not be found.

88. Staff knew that Mr Ison was unhappy to be placed at Bowling Green AP, a long way from his family and, therefore, from support networks. The AP Manager told the investigator that, due to its location in Carlisle, a significant number of people placed at Bowling Green were unhappy about being there and that it was not feasible for him to transfer everyone who wanted to move. The AP Manager said that while he was aware that Mr Ison had been anxious, he believed he was coping and it was therefore not a priority to try to find a transfer.

89. Mr Ison's probation officers had regular contact with him and were responsive to the concerns he raised about the location of the AP. This is evidenced by the actions taken by the COM, who explored the option of a transfer and reduced his placement to eight weeks.

90. We are satisfied that reasonable actions were taken by all professionals involved to manage Mr Ison's concerns about the placement and we therefore make no recommendation.

Assessment and management of risk

91. Mr Ison had no recent history of suicide attempts or self-harm. He had not been monitored under suicide prevention measures while in prison on his most recent sentence and prison staff did not pass on any concerns about Mr Ison's risk in the run up to his release.

92. We are satisfied with the AP's initial assessment of the level of oversight and support Mr Ison required when he arrived at Bowling Green. It is well documented that Mr Ison complained of feeling anxious and this was also identified by staff. There is evidence that AP and probation staff talked to him about his anxiety and encouraged him to get involved in diversionary activities, as well as to seek help from the GP. These were reasonable and proportionate responses at the time.

93. In the early hours of 11 May, Mr Ison's anxiety appeared to significantly increase. While we are assured that the probation services officer took the appropriate action

at that time to support Mr Ison, we consider that this was a significant event and consequently a review of his SASP should have been carried out to ensure that Mr Ison was receiving the right level of support and oversight.

94. When Mr Ison appeared highly anxious again two days later, a residential worker dealt with the immediate situation in a caring and professional manner. He sought to determine if there was an immediate risk by asking Mr Ison if he had any thoughts of suicide or self-harm and he spent a considerable amount of time talking to him. He then made sure that both the AP Manager and COM were informed of what had happened and he contacted the MHCT to ask for Mr Ison to be urgently assessed. While we note that arrangements were made for Mr Ison to be seen by the COM later that day, arrangements should also have been made for an urgent review of his SASP in line with policy. We therefore make the following recommendation:

The Approved Premises Area Manager, North-West, should ensure that Bowling Green staff are clear about the requirement to review the SASP when there has been a significant event.

Management of medications

95. Mr Ison was released on a Wednesday before a bank holiday weekend with only a four-day supply of mirtazapine. We have not been able to establish why Kirkham released him without the standard supply of a month's medication.

96. When Mr Ison handed in his medication to AP staff, the residential officer would have seen that his medications were due to run out over the weekend and an urgent prescription was required. While the GP registration form was completed on the day of his arrival we cannot be certain if this was communicated to the surgery and there is no record of any contact with the GP to request an urgent prescription.

97. Mr Ison ran out of medication a second time. As the medication administration records show a running total, staff should have been more proactive in alerting him to this and supporting him to obtain a new prescription.

98. A copy of Mr Ison's medicines in-possession risk assessment could not be found and not all actions relating to the administration of medicines were recorded properly. We therefore make the following recommendation:

The Approved Premises Manager should:

- **remind staff to take account of the quantity of medicines that they hold and alert a resident when a medication is running low; and**
- **record any conversations or actions they take either on the medication administration record or the resident's personal record**

Head of Healthcare at HMP Kirkham to note

99. Staff at Kirkham were unable to access Mr Ison's records so could not confirm why Mr Ison was released with such a small supply of his medication. We routinely request from prisons the medical records of prisoners who have since been

released in our AP and post-release death investigations and are surprised that Kirkham could not apparently access Mr Ison's records. The Head of Healthcare will want to consider any learning from this case.

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Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100