

**Investigation into the circumstances surrounding the
death of a woman, a resident of Crowley House Approved
Premises, in the West Midlands Probation Area, who died
on in March 2009 in Selly Oak Hospital**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

August 2009

The woman was admitted into Selly Oak Hospital on 19 January 2009 after being taken ill whilst a resident of Crowley House Approved Premises. She died on in March aged 49. The cause of death has been registered by the Coroner for Birmingham an infection of blood. I understand from the Coroner that the woman's death will not be the subject of an inquest.

The investigator, the Family Liaison Officer (FLO) and I would like to offer our condolences to the woman's family and friends.

I wish to thank the Senior Probation Officer at Crowley House, for her assistance in making the necessary facilities and information available to the investigator. I am also grateful for the assistance of Senior Probation Officer for Offender Management, for her invaluable support in preparing the probation files for the investigator.

It is not normal when investigating a death at an approved premises for there to be a clinical review, however in this case the investigator asked for one to be carried out into the care and treatment the woman received both in custody and whilst at Crowley House. I am extremely grateful for the assistance of the South Birmingham Primary Care Trust, who appointed their Head of Governance, a Registered Nurse, to conduct a review.

For the purpose of the report, I have concentrated on the period after 12 January 2009, when the woman was released from HMP Peterborough to Crowley House. However, as she was initially remanded in custody on 4 October 2004 for the original offences, I have identified and included the salient points of her custodial period from that date. This report makes four recommendations.

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1. Clinical Review

SUMMARY

The woman was originally remanded into prison in October 2004. She had been jointly charged, along with her husband, with a number of serious offences against members of her family. The woman remained on remand until June 2005, after which she was sentenced to 66 months imprisonment. Additionally, the court made an order for her to be placed on the Sex Offender Register for ten years.

As part of the normal progression through the prison system she went to a number of different prisons. She was finally released on licence, from HMP Peterborough in January 2009. A condition of the licence was that she was required to live at Crowley House.

The woman had a number of health problems and had been assessed as requiring the assistance of a local learning difficulties team. In addition she required assistance with her longer term accommodation plans. Soon after her arrival at Crowley House her health began to cause concern for staff working there. They sought assistance on a number of occasions from medical staff based at a surgery close by.

On 13 February the woman went to see a doctor at the surgery, and he admitted her into Selly Oak Hospital as an emergency patient. The reason for her admission was chronic obstructive airway disease and exacerbation of chronic obstructive pulmonary disease.

Whilst in hospital, a number of residents visited her. They reported back to Crowley House staff that her condition appeared to have improved. However the woman did not get better and she remained in hospital until her death in March.

This report will show that her medical care whilst at Crowley House was satisfactory, although it questions whether she was best placed there. However, the support she received from the West Midlands Probation Area when in hospital is disappointing.

THE INVESTIGATION PROCESS

1. Once the Ombudsman's office was notified of the woman's death, the investigation was allocated to a senior investigator. Assisting him was one of the (FLOs).
2. On 2 April the investigator travelled to Crowley House to attend a meeting with the Senior Probation Officer. Also present were, District Manager for Approved Premises, Offender Manager and Senior Probation Officer for the Offender Manager.
3. The investigator was told that the woman had been released on licence from HMP Peterborough, to live at Crowley House in January 2009. To assist the clinical reviewer, the investigator contacted Director of Peterborough and asked for the woman's prison medical record to be forwarded to him. I am grateful to the Director for his assistance. Before leaving Crowley House, the investigator arranged to return at a later date to begin his investigation.
4. The investigator returned to Crowley House on 12 May to attend a meeting with the clinical reviewer. Following that meeting the investigator and the Head of Governance gave immediate feedback to the Senior Probation Officer about an urgent finding. The feedback was not directly connected to the woman's death, but concerned the recording and administration of medicines at Crowley House. It was clear to the Head of Governance that the woman's medical notes did not contain all the information about the medication that she had been prescribed, nor did the records note whether the medication had been taken or not. Additionally the woman had not signed the records to show that she had received the medication. The Senior Probation Officer accepted the feedback and agreed to implement changes that day to ensure the staff complied with the Probation Service Approved Premises guidance on the administration of medication.
5. As well as meeting the Head of Governance the investigator met informally with the Senior Probation Officer and the Offender Manager. The purpose of the meetings was to clarify what had happened to the woman after 12 January 2009. As part of the Ombudsman's normal procedure when investigating a death, he invites the family of the deceased to contribute towards his investigation. He gives them the opportunity to meet the investigator and FLO and to read the report when it is completed.
6. The FLO contacted West Midlands Probation Area regarding the woman's next of kin and was told that her children did not want any contact. However, as her husband was still in custody the FLO contacted the prison where he was being held and invited him to contribute.
7. The husband asked to be kept informed of the investigation and wanted to know how she had died and whether her health problems had been dealt with. I believe the report will answer his questions.

CROWLEY HOUSE APPROVED PREMISES.

8. Approved Premises, formally known as Probation and Bail Hostels are approved by the Ministry of Justice within Section 9 of the Criminal Justice and Court services act 2000. Their purpose is to provide an enhanced level of residential supervision in the community, as well as a supportive and structured environment.
9. Crowley House is one of very few approved premises solely for women and situated within attractive grounds in South Birmingham. It provides accommodation for 20 women, especially those on post-supervision licence. About one quarter of the residents, including the woman, are subject to Multi Agency Public Protection Arrangements (MAPPA).
10. The MAPPA are a set of arrangements designed to manage high risk offenders in the community. There are three levels of MAPPA:
 - **Level one**

Level one MAPPA is normally managed by a single agency and is the lowest monitoring procedure available under the MAPPA system. However this often involves a close liaison with other agencies, in particular the police.
 - **Level two**

As with level three, anyone identified as falling into the level two heading would be managed by representatives from agencies including probation, police, social services, housing, health and education.
 - **Level three**

Anyone subject to level three is considered as being the highest risk cases, where more than one agency will oversee the management of the person concerned.
11. The priority of Crowley House is to supervise women of medium or high risk of harm to the public and above. Additionally a full-time drug-worker works at the premises. A key worker system offers support and guidance regarding aspects of the sentence plan, subject to a quarterly review with the Offender Manager.
12. Residents are registered with a local doctor's practice and have the same access and confidentiality as any other patient. Whenever medication is prescribed, the prescription is supplied to the approved premises and held securely by staff in a locked cabinet.
13. At Crowley House, staff are responsible for issuing medication to residents at the appropriate times. Both the resident and staff member issuing the prescription should sign a prescription chart to show issue and receipt.

KEY FINDINGS

14. The woman was born on in July 1959. According to the Offender Manager, she had been identified as having learning difficulties. It is not known if she had any long term physical health conditions. He said that she had one previous conviction for two offences of deception and one offence of harassment. For those offences, she was given a six month Probation Order and a six month Restraining Order, on 20 April 2000.
15. In October 2004 the woman appeared before Halesowen Magistrates Court, having been jointly charged with her husband for her part in serious sexual offences against members of their family. Magistrates committed her to appear for trial at Wolverhampton Crown Court on a date to be fixed and remanded her into prison pending the trial.
16. At the Crown Court trial, which was held in June 2005 she was sentenced to 66 months imprisonment, which was made up of a five year concurrent sentence for aiding and abetting, and a six month consecutive sentence for intimidation. An order was also made for her to be placed on the Sex Offender Register for ten years. In addition, strict restrictions and conditions were placed on her about who she was allowed to meet, or contact, which meant that she was not allowed to contact or meet her victims. Due to the nature of her offences and because she had been in contact with victims of her crime she was registered by the Probation Service as coming under the provision of the MAPPA level two.
17. On 17 June 2005 the woman was transferred to HMP New Hall, which is a women's prison situated in West Yorkshire. The following month, she was transferred to HMP Low Newton, which is on the outskirts of Durham.
18. Just under two years later, on 13 June 2007, a referral was submitted by a seconded probation officer at Low Newton for the woman to move to Crowley House after her release from prison. Five days later, the Senior Probation Officer at Crowley House agreed to the transfer in the expectation that the woman would be given parole. However, the Parole Board met on 2 August and did not approve her release at that stage. Instead her release date was set for the non parole date, which was the following year.
19. On 3 June 2008, in order to facilitate the transfer to Crowley House and her release from prison the woman was taken to HMP Eastwood Park in Gloucestershire. The next day she was released from Eastwood Park and taken to Crowley House by the Offender Manager and one of his colleagues both from the West Midlands Probation Area.
20. The Offender manager told the investigator that the woman settled into Crowley House much better than had been expected. His expectation had been that she would have been very resistant to becoming a resident. She had previously said to a probation officer that she would refuse to live in approved premises accommodation and that she wished to live in her home area, in another part of the West Midlands.

21. On 24 July the woman was taken ill after experiencing difficulty with her breathing and was admitted to Selly Oak Hospital. The clinical reviewer notes that the woman was diagnosed as having Type II respiratory failure, with pulmonary hypertension (PH). (PH is an increase in blood pressure in the pulmonary artery, pulmonary vein or pulmonary capillaries, leading to shortness of breath, dizziness, fainting and other symptoms, all of which are exacerbated by exertion.) The Head of Governance adds that pulmonary hypertension can be a severe disease.
22. Contained within the woman's Probation Service Case Record there is an entry noting that at 10.45pm the following day she had not returned to her hospital ward after being allowed out to have a cigarette. It was thought that she was making her way back to Crowley House. Staff at Crowley House contacted the Duty Manager to tell her what had happened. The Duty Manager told the staff to telephone Bourneville Lane Police Station and ask them to look for the woman. If they found her, she should be taken back to Crowley House.
23. The case records shows that at 11.30pm the Duty Manager was planning to contact a police station in the area where the victims lived, because her whereabouts were still unknown. Additionally, because she was in breach of her licence conditions the Duty Manager took the decision to begin immediate recall proceedings via the Ministry of Justice (MoJ) recall section. This meant that, when she was found and recall was approved the woman would be returned to prison.
24. At 1.15am the following morning the woman returned of her own accord to Crowley House. The case records show that she told staff that she had taken a wrong turning, after making her way back to Crowley House. The note adds that she was still carrying medical tubing in her hands and that she wanted to go to bed.
25. Police arrived at Crowley House at 4.45am, and arrested the woman. Two hours later, the arresting officer telephoned Crowley House to tell them that she had been returned to Selly Oak Hospital where she remained for about four days.
26. The Duty Manager made a further entry in the case record. Although at midnight she had felt that immediate recall was appropriate, both she and the woman's Offender Manager now thought that it was no longer necessary. The note adds that the Offender Manager would try to stop the recall. The Duty Manager told the investigator that this was not possible, because once the process for immediate recall begins, it cannot then be stopped.

27. On 11 August the woman was discharged from hospital and taken by taxi to Crowley House. Staff at Crowley House telephoned Bourneville Lane Police Station to tell them that she had returned. At 9.40pm, police officers arrived and arrested her before then taking her to the police station. Following the licence recall the woman was taken to HMP Peterborough to continue her sentence. Her sentence was later reviewed by the MoJ and they agreed to re-release her back to Crowley House.

12 January 2009

28. On 12 January 2009 the woman was released from HMP Peterborough and taken by a probation officer, to Peterborough Railway Station. The probation officer placed her on a train for Birmingham New Street Railway Station, where she was met by the Offender Manager and a colleague who took her back to Crowley House.
29. Because the woman was asthmatic, she had been prescribed with an inhaler, which she was allowed to take with her when she was discharged. When she arrived at Crowley House, she told the staff that the inhaler was empty. Crowley House staff contacted the surgery and asked for a replacement, which was supplied later that day.
30. The Clinical Reviewer said in her clinical review that staff were concerned about the woman's health and social needs. They had to remind the woman of the need to collect and take her medication, as well as assist her with personal hygiene. The woman was assessed by the doctor and, as well as being prescribed inhalers, she was given skin cream to help control psoriasis. The doctor also referred her to the learning disabilities unit for assessment. The Clinical Reviewer has noted in her clinical review that the woman found it difficult to cope with her personal hygiene. She highlights occasions when her psoriasis would give off an "offensive odour" and as well as shedding skin, her sores would bleed onto communal furniture.
31. Two days later, on 14 January the woman went to a meeting with a local housing association to discuss her longer term housing needs and make an application for accommodation. She was also taken to a local police station where she was registered as a sex offender.
32. On 19 January the woman was admitted once again to Selly Oak Hospital after experiencing breathing difficulties and diarrhoea. She was discharged the same day along with a follow up outpatient's appointment to examine her sleeping pattern. It was noted in the probation records that staff were concerned about her health needs and ability to manage at Crowley House. In her clinical review the Clinical Reviewer notes that the woman was given assistance with her dressings, application of creams and personal hygiene. Additionally an appointment was made for the woman to see a doctor.

33. In the meantime, the housing association had rejected the woman's application for housing in part due to her previous rent arrears and also because she required a higher level of support than they were able to offer. The Offender Manager told the investigator that in addition to her learning difficulties the woman had a number of complex medical issues, including personal hygiene and psoriasis. He added that she struggled to take care of herself and required basic support to ensure that she was able to maintain herself, including reminders to take her medication. Concerned that Crowley House could not manage her needs, an action plan was put in place for the Offender Manager to appeal to the housing association to ask them to reconsider the application. Additionally, he was asked to liaise with a doctor from the learning difficulties team, to seek alternative accommodation providers and examine the rent arrears. With the exception of making a formal request to the housing association, all the other actions were carried out. The reason that he did not speak to the housing association, was because he wanted to speak in the first instance to the doctor, which he saw as being as more important.
34. The Offender Manager told the investigator that he contacted a doctor, who he knew was involved in the woman's care. The doctor told the Offender Manager that, because the woman had learning difficulties, she was going to recommend that the referral was accepted by the learning difficulties team.
35. In the meantime, on 22 January the Offender Manager met the woman at Crowley House for a routine meeting. He told the investigator that she was clearly unwell, had become incontinent and was failing to care for herself properly. The woman told him that her medication was causing her to be incontinent, but the Offender Managers view was that the woman was minimising her health problems and her ability to look after herself.
36. The Offender Manager spoke to staff at Crowley House to examine how best to meet the woman's needs. He and the staff thought that Crowley House was unsuitable place for her. It was agreed that they should continue to look for alternative supported accommodation, as well as liaising with the learning difficulties team.
37. The next day, 23 January the doctor from the learning difficulties team carried out a learning disability assessment. She concluded that learning disabilities were evident and recommended further assessments. The Head of Governance said in her clinical review that the woman was sleeping excessively and had become difficult to wake. It was also noted that the woman's arms were itchy and infected.
38. The Duty Manager told the investigator that, on the same day, she was in contact with the doctor to ask for the assistance of a district nurse. She told the investigator that, unfortunately, a nurse was not immediately available. The Head of Governance has noted that a written request was made three days later. She said the referral only indicated the need for a district nurse, but that there should have been a request for social care assistance. The Head of Governance notes that there is no record of any response from the

doctor and the staff at Crowley House were unaware that no action had been taken.

39. On the same day the woman told staff at Crowley House that her doctor had told her to discontinue with all medication. Her records show that the doctor was contacted and asked to confirm what the woman had said. The doctor told staff that this was not true and said that the woman should continue with her medication.
40. The following month, on 4 February the woman attended the outpatient appointment for sleep tests. As the tests were carried out over a 24 hour period, she returned to hospital the following day to complete the appointment. The results of the tests are not known.
41. On 12 February, a meeting took place with the learning difficulties team to discuss the doctor's earlier recommendation. At that meeting it was agreed that the team would accept the referral.
42. The next day, 13 February the woman was taken ill again and Duty Manager went with the woman to see a doctor. The doctor asked for an emergency ambulance to take her to Selly Oak Hospital, as she was experiencing difficulty with her breathing. It was noted in the Probation Service Case Record that the woman was feeling light headed and that she looked pale. The Head of Governance has noted the reason for the urgent admission was because of shortness of breath, cyanosis (a blueness of the lips) and oedema (fluid retention).
43. On 14 February, a member of Crowley House staff contacted the hospital to find out how the woman was. They were told that she had type II respiratory failure and was using a face mask to help her breath. (Type II respiratory failure is based on the partial pressure of carbon dioxide).
44. Over the following days, a number of residents from Crowley House visited her in hospital. They reported to staff that she had asked for knitting materials and money to allow her access to a television. Residents also reported that her skin colour had improved.
45. On 17 February, according to the case record the doctor from the learning difficulties team telephoned Crowley House to say that a referral had been made for the support of community nurses. The doctor also said that an assessment was being planned to consider the woman's basic needs and the level of living support that she would require in the longer term. There was also an entry noting that the woman had been seen by a consultant and that she was not going to be discharged that day, due to a problem with her oxygen levels.
46. A member of Crowley House also made a note about a telephone conversation with a staff nurse at the hospital. The staff nurse told her that she had been visited by her daughter. Aware of the restrictions placed on the woman the member of staff asked the staff nurse for a description of the

visitor. From the description, the member of staff believed that the person was actually another resident. The investigator identified the resident concerned and she confirmed that she had been to see the woman on a number of occasions. The resident said that nursing staff who had assumed that she was the woman's daughter, but that she had corrected them saying that she lived at the same house as the woman and was not related.

47. Over the next few days, a number of entries were made in the case record noting the woman's condition. On 25 February, an entry suggested that concerns had been raised (it is not clear by whom) that she was refusing oxygen treatment.
48. On 7 March, an entry was made in the woman's case record that someone from the hospital had telephoned Crowley House to say that her health was deteriorating. She had also told a nurse that she wanted to see her daughter, but had then told the nurse that her daughter would not see her.
49. Due to the restrictions as to who the woman could have contact with, a number of options were considered by staff at Crowley House. They also discussed the woman's husband, whom she had identified as her next of kin, and who was still in prison. They contacted the prison where her husband was held and recorded that a prison manager took the decision to tell him, but only if she died. Additionally, the notes show that the ward where the woman was being treated had been closed for infection control. (Head of Governance has contacted Selly Oak Hospital as part of this investigation and confirmed that ward S6 was closed between 6 and 11 March due to an outbreak of *clostridium difficile*. She said that this meant the ward was closed to new admissions only and not visitors, although the number of visitors would be restricted.)
50. At 4.00am the following morning, staff at Crowley House received a telephone call from the hospital telling them that the woman's condition had deteriorated further. Staff again discussed who should be contacted in the event of her death.
51. The staff at Crowley House were informed later that day that the woman had died (it is not clear from the records exactly when they were told). After receiving the message, a member of staff telephoned the prison where the woman's husband was located and told a manager about her death. The manager (who was not named) said that her husband would be told.

Events following the woman's death

52. The investigator asked one of the residents how she had been informed of her death. She said that all residents and staff on duty were called together and told. The resident added that staff had been supportive, and told the investigator that a memorial had taken place. She went on to say that a number of residents and two staff had attended the woman's funeral. The resident told the investigator that she hopes that residents will be allowed to place a permanent memorial at Crowley House in memory of her.

ISSUES

Care and support

53. I am satisfied that, proper arrangements and discussions took place to ensure that she was supported in the short and the longer term. It was clear to probation staff that the woman's needs were numerous and that she required a level of support which needed careful planning. In order to do this, a number of agencies were involved in that process, but sadly the woman did not benefit from the work carried out on her behalf.
54. As well as the care and support for the woman's longer term needs, I have considered the immediate care given to her when she was taken ill. I am satisfied that staff at Crowley House ensured that she received the appropriate medical care and, when it was evident that her health had deteriorated, she was taken immediately to hospital.
55. However, having said that, I have been disappointed to learn that following her admission into hospital on 13 February, no member of probation staff went to see her. I am aware that some residents went to visit her, and that staff made daily telephone calls to enquire about her progress. However, in my view, this was not the type of support that someone like her required. As well as there being no record of probation staff visiting the woman there is no record of any member of staff even speaking to her on the telephone. Given the close working relationships between Crowley House staff and residents, the West Midland Probation Area have let themselves down by failing to demonstrate that the care for any resident taken ill extends beyond the grounds of Crowley House.
56. The investigator discussed this issue with Crowley House managers and the District Manager of Approved Premises and was told that the ward had been closed due to infection control. However, the first mention of infection control is not recorded in the woman's case record until 7 March, some three weeks after she was first admitted. Additionally, it was clear to the investigator that Crowley House staff knew that residents were visiting her and so presumably must have realised that the infection control did not preclude visitors. Otherwise it would beg the question why staff were allowing residents to visit her. In fact, the ward had not been closed to visitors and therefore there was no reason for Crowley House staff not to have visited the woman.
57. At that same meeting, the investigator was told that there is no requirement by the West Midland Probation Area for its staff to visit residents when they are hospitalised. I have to say that I find this extremely disappointing. To leave someone like the woman or in fact any resident, alone in hospital for so long, was in my view inappropriate and not within the spirit of supportive care. Although I am pleased that Crowley House managers quickly accepted the investigators comments, I make the following recommendation:

The West Midlands Probation Area should consider how best to ensure that residents who are admitted to hospital, are properly supported.

Clinical Care

Transfer from prison to Crowley House

58. In her clinical review the Head of Governance said that Crowley House was not an appropriate place for someone requiring the level of care that the woman needed. She said the woman required constant reminders about her personal hygiene, which was exacerbated by psoriasis and excessive sleeping and breathing difficulties especially in the communal areas of the building.
59. The Head of Governance said the transfer from prison to Crowley House did not include a health or social needs assessment. Had it done so, it would have allowed better insight into the level of care the woman required. Additionally it would have better informed the suitability, or otherwise, of the woman to be placed at Crowley House.
60. That said I accept there were few alternatives available other than possibly moving her to premises away from her home area. The Head of Governance makes the following recommendation:

The National Offender Management Service should consider whether the assessment prior to any transfer ensures that the placement is suitable and includes a learning disability assessment when appropriate.

Managing residents' medication

61. The Head of Governance said the management of residents' medicines is in line with Probation policy. However, she notes significant failures in transferring prescriptions onto an internal card and of the administration of the medicines. This was raised with the Senior Probation Officer by the investigator as an urgent finding. The Head of Governance said the documenting and signing of the records was inconsistent with other written records and in many cases, they did not exist. She adds that the documentation suggests that courses of antibiotics were not administered in accordance with the prescription. She goes on to say that there is no firm evidence that this impacted on the care or death of the woman. The Head of Governance makes the following recommendation:

The West Midlands Probation Area should provide immediate training to its approved premises staff in the requirements for correct signing of medicines on the internal medicines record card.

62. To prevent mistakes in the handwritten transferring of prescription data onto the approved premises internal medical card, the Clinical Reviewer makes the following suggestion. She suggests that pharmacists supplying medication to residents of approved premises should be asked to consider supplying an additional prescription label, as done in healthcare setting such

as nursing homes, which can then be attached to the resident's internal medical card.

63. I understand from West Midlands Probation Area that, whilst they can ask the pharmacist to print an extra label, they cannot insist on it. They said their early discussions with pharmacists suggest that some would be agreeable, whilst others would not.

Prescriptions

64. On at least one occasion, a prescription written for the woman by a doctor in the community was found to have the wrong name and was in fact meant for another patient. In her clinical review the Clinical reviewer said that prescriptions should be checked for the correct patient details before being given to a patient or pharmacist. Although I make no formal recommendation, the PCT may wish to consider the matter further. I understand the PCT have reminded all practices and pharmacies of the need for accurate recording and checking of patients details on all prescriptions prior to them being released

Request to doctor for district nurse

65. In her clinical review the Clinical Reviewer notes that following a request by Crowley House for the assistance of a district nurse, the letter was not acknowledged by the community doctor. The Clinical Reviewer makes the following recommendation:

The South Birmingham Primary Care Trust should ensure that the medical practice responsible for Crowley House responds to all requests and document the response in the patients' medical notes.

Case Record

66. The quality of the entries contained with the woman's case record has proven to be invaluable to the investigation. The case record contains good quality, chronological entries, noting important information and decisions. Although I make no formal recommendation, I invite the Chief Probation Officer for West Midlands to share my comments with his staff.

CONCLUSION

67. Like the Clinical Reviewer, I do not believe that Crowley House was best placed to meet the woman's medical and social needs. However, given that there was little alternative, I am satisfied that staff there did their best with the limited resources available to them.
68. I do not believe that the woman's health suffered any detriment by being at Crowley House. Probation staff ensured that medical assistance was sought at the earliest opportunity and when necessary.
69. What I do find disappointing is the lack of contact with her by probation staff at Crowley House when she was admitted into hospital. I trust that the Probation Area will reflect on this issue and ensure that this does not happen again.

RECOMMENDATIONS

1. The West Midlands Probation Area should consider how best to ensure that residents who are admitted to hospital, are properly supported.

The West Midlands Probation Area has accepted the recommendation.

2. The National Offender Management Service should consider whether the assessment prior to any transfer ensures that the placement is suitable and includes a learning disability assessment when appropriate.

The National Offender Management Service has responded to the recommendation. They said "Access to suitable supported accommodation for offenders with complex needs is often problematic, and this was a classic case of an offender being admitted to an approved premises as the 'least bad' option available, even though it was recognised that the approved premises would struggle to meet all the woman's needs"

3. The West Midlands Probation Area should provide immediate training to its approved premises staff in the requirements for correct signing of medicines on the internal medicines record card.

The West Midlands Probation Area did not accept the recommendation. They said "This recommendation is not accepted as it stands, though the practice failure it highlights is acknowledged. In our view, this is an issue about compliance not knowledge. The Area's requirements in respect of medication handling and recording are clear; what happened in this case is that those requirements were not met. As the report notes, the manager at Crowley agreed immediately that discovery of this failure demanded immediate corrective action, which she undertook by way of a formal reminder to all her staff. The District Manager will ensure that a similar reminder is issued to staff at our other Approved Premises as part of the 'lessons learned' follow-up to this report."

4. The South Birmingham Primary Care Trust should ensure that the medical practice responsible for Crowley House responds to all requests and document the response in the patients' medical notes.

South Birmingham Primary care Trust has instructed the Medical Practice to respond to all requests from Crowley House and ensure this is documented in the patients' medical notes. The PCT has also shared this with all locality managers to ensure all medical practices are reminded of the requirement to appropriately and timely respond to all requests and the subsequent documentation of their actions in the Patient medical notes.