

**Investigation into the circumstances surrounding the
death of a man at HMP Birmingham
in December 2009**

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

March 2011

The man was a prisoner at HMP Birmingham when he died of disseminated cancer (also known as secondary or generalised cancer) in December 2010.

I would like to extend my condolences to his family and friends and all those affected by his death.

My colleague was appointed to investigate the circumstances of the man's death. I would like to apologise for the delay in issuing this report. A clinical review was commissioned from the local Primary Care Trust and carried out by a Clinical Director. I am grateful for his contribution to this investigation.

I am also grateful to the assistance provided by the Governor of HMP Birmingham and his staff. In particular, I would like to thank the prison's Liaison Officer for his help.

The man had long standing health problems when he arrived at HMP Birmingham and he received almost daily medical care whilst he was in prison. As a result of his diabetes and poor circulation he underwent leg amputations and, during his penultimate stay in hospital, was found to be suffering from cancer. He died from cancer shortly afterwards.

I make one recommendation in relation to contact with the designated next of kin.

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 prisoners involved in my investigation.

Jane Webb
Acting Prisons and Probation Ombudsman

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SUMMARY

The man was born on 31 May 1947. He was sentenced to six years imprisonment at Crown Court on 2 August 2007 for various counts of sexual assault.

He had suffered from diabetes for many years before coming into prison. He was prescribed insulin to manage the condition. He was a heavy smoker and also had a history of heart disease.

Throughout his time in prison, the man was looked after by the prison medical team. Despite various attempts to heal leg ulcers and improve his circulation, he had one toe on his right foot amputated in September 2008. His circulation did not improve and, in April 2009, his right leg was amputated above the knee.

He was then treated by healthcare staff every day but, by November 2009, his health had continued to deteriorate and, as a result of continuing poor circulation, doctors decided to amputate his left leg above the knee.

Later the same month, the man was given an x-ray which suggested that he had lung cancer. However, he remained in poor health and, although he was informed that it was likely that he had cancer, doctors were unable to start treatment.

His health continued to deteriorate and he was taken to hospital with low blood sugar levels, low blood pressure and diarrhoea on 27 November. He did not recover and he died in December. The post mortem gave the cause of death as disseminated cancer.

I make one recommendation as a result of this investigation. This relates to contact with the designated next of kin.

THE INVESTIGATION PROCESS

1. Following notification of the man's death, an investigator was appointed to conduct the investigation. HMP Birmingham provided a copy of his prison records, including his medical records. Notices were issued to prisoners and staff inviting anyone who had information regarding his death to make themselves known to the investigator. No other witnesses came forward.
2. The investigator visited HMP Birmingham on 24 March 2010 to carry out recorded interviews with staff.
3. One of the Ombudsman's Family Liaison Officers contacted the man's step-daughter (his designated next of kin) to explain the role of the Ombudsman and to offer the opportunity to participate in the investigation. His step-daughter explained that she and other family members had not kept in contact with him since his arrest but she was happy to help in any way she could. She was acting on behalf of her mother, the man's ex-wife.
4. The man's step-daughter mentioned there had been some confusion when the prison came to visit her mother to break the news of his death almost a week after he had died. This was despite the family's request that because of her mother's age and frailty she (the step-daughter) be the first point of contact for the family. She said they did not want to complain but she was anxious to ensure that the same thing did not happen to another family as it had caused them some distress and confusion.
5. The local Primary Care Trust was commissioned to conduct a clinical review. They appointed a Clinical Director to conduct the review.
6. The man's step-daughter received a copy of my draft report as part of the consultation process. Although she did not wish to raise anything with regard to the investigation findings, she was concerned there were factual inaccuracies relating to the funeral in the report. The investigator would like to apologise for the distress caused to the family by suggesting they attended his funeral. This information was supplied by a member of prison staff to her and was incorrect.
7. The National Offender Management Service (NOMS) also responded to the draft report, and specifically to the recommendation. I discuss this issue further on page 16.

HMP BIRMINGHAM

8. HMP Birmingham is situated in the Winson Green area of the city. It is a category B local prison, holding convicted and unconvicted adult males. It serves the Crown Courts of Birmingham, Stafford and Wolverhampton. It also serves the Magistrates' Courts surrounding the city of Birmingham.
9. The prison was built in 1849. In 2002, additional accommodation was built which provided a further 450 prison places, increasing the operational capacity to 1,450 beds. The Healthcare Unit has 34 inpatient beds.

Independent Monitoring Board (IMB) report

10. Each prison has an Independent Monitoring Board (IMB) whose role is to monitor the prison and report any concerns about the way prisoners are treated. Board members are able to visit any area of the prison at any time and have direct access to any prisoner who they wish to see, or who requests to see them. The IMB holds regular meetings in the prison, with the Governor attending for part of the meeting. The Board produces an annual report that is submitted to the Secretary of State for Justice.
11. In their 2008 annual report (this is the last published report), the IMB said that they were impressed with the dedication and professionalism of the staff. They also said that, as the prison was undergoing "tremendous change", it was difficult to write a measured report as the changes were expected to take some time before becoming embedded.
12. In relation to healthcare, the IMB wrote that there was a lot of uncertainty within the Offender Health Department as a whole as the contract to provide healthcare services at Birmingham was coming up for competitive tendering. (The contract has since been awarded to Birmingham and Solihull Foundation Mental Health Trust.) This had a destabilizing effect on staff at all levels and recruitment was proving difficult.
13. The IMB said that they were disappointed that the PCT had not taken up the suggestion of using Telemedicine (the use of communications or information technology for the delivery of clinical care) as a diagnosing tool. This would have produced saving in escort costs and meant fewer cancelled appointments for prisoners. During the year there were 912 outpatient appointments of which 145 were cancelled, although this was an improvement on the previous year.

Her Majesty's Chief Inspector of Prisons

14. Between 19 and 23 February 2007, Her Majesty's Chief Inspector of Prisons carried out a five day announced inspection of HMP Birmingham. An unannounced full follow up inspection took place between 2 and 11 December 2009.
15. In the introduction of her follow up report (which was issued in February 2010), the Chief Inspector said that, while some progress had been made, there was still a considerable amount to do to ensure a safe, decent and effective prison. She also stated that

"Health Services were well managed, and mental health provision, including day care, had greatly improved, but the shortage of nurses [the inspection found that there were 13 nurses in post and 15 vacancies] impacted on primary and inpatient care."

KEY FINDINGS

16. The man was convicted of various sexual offences at Crown Court on 2 August 2007. He had previously been remanded to HMP Birmingham on 16 May 2007, when it was noted during a medical screening that he had an ulcer on his left foot for which he was prescribed antibiotics. He also suffered from type 2 diabetes mellitus. (Diabetes is a metabolic disorder characterized by high blood glucose, often because insulin has become less effective or because there is insulin deficiency. Diabetes is often initially managed by increasing exercise and dietary modification, but as the condition progresses medication may be required.)
17. In September 2007, staff noted that the man had an ulcer over his right lateral malleolus (the outside of the ankle bone on his right leg) and had poor sensation there. On 10 October, it was noted that he had a chest infection and was producing thick phlegm when he coughed.
18. By November, the wound to the man's right ankle appeared "necrotic, sloughy and malodorous" (necrosis occurs when skin cells die, sloughy is dead tissue and malodorous means an offensive odour) and it was suggested that he should be sent for an urgent review at the diabetic foot clinic. On 18 November, the wound needed immediate attention and the prison doctor was informed that the man should go to hospital.
19. An appointment was arranged for an x-ray to be taken at hospital on 5 December, but this did not take place as he was unable to get into the taxi that had been arranged for him. No alternatives appear to have been arranged to facilitate his attendance. Between 5 December and 5 February, medical staff at the prison constantly reviewed his wound.
20. On 14 January, it was agreed that the man's dressing needed to be changed daily. The nurse spoke to him about his diet and his smoking. He admitted to eating sugary sweets and said that he intended to quit smoking when he left prison. At the same time he complained that he had not been receiving his diabetic sandwich (a sandwich especially prepared for diabetics). A member of healthcare staff updated the medical log to note that she had emailed the prison kitchen about his sandwich. The following day, the Head of Healthcare noted that his leg ulcer had deteriorated and chased the diabetic clinic appointment.
21. On 5 February 2008, a member of healthcare staff at the prison wrote in the log that the hospital appointment was still required and noted that it was very uncomfortable for the man to travel by car. He was admitted to hospital on that day and stayed on Ward 21 until he was discharged eight days later. When he saw healthcare staff after his return from hospital, his leg appeared to be clean and dry with no smell. Between February and July, his leg was constantly reviewed and the dressings were changed.
22. However, by 23 July, the man's toe and ankle had become infected. He was unhappy that the hospital had cleared his infection but it had returned after he came back to prison. His leg ulcer continued to get worse and, on 12 August, he went to the accident and emergency department at the hospital. On 13 August, his leg became more painful and he was admitted to a hospital ward.
23. After the admission, doctors found that the man's toe had become gangrenous (this is when body tissue decays and dies, often occurring in a limb, caused by insufficient blood supply). It was amputated on 15 September, and he was discharged from hospital 11 days later. He was able to walk with assistance but he usually used a

wheelchair. A mobility needs assessment was carried out and he was given a ground floor cell close to the nursing station. He was prescribed bed rest and a high protein diet. On 31 October, a review of the amputation site noted that it was still covered in dead tissue which was leaking blood and other fluids.

24. On 2 December, the man complained of leg cramps and this pain continued throughout December and January. The Head of Healthcare noted that the pain was chronic and intermittent but as he had already been prescribed quinine for his leg pain, the dose could not be increased. He was prescribed liquid tramadol (a pain killer) which he took twice a day under supervision. On 15 January 2009, he was referred as an outpatient to hospital and was seen later that month by the vascular consultant surgeon who said that an ultra sound was needed to check the arteries in his right lower leg.
25. According to the clinical review by the Clinical Director, the man was seen again in the vascular clinic at hospital on 4 February. However, the medical notes from the prison do not record the visit, but instead note that he was seen in wards 1 and 2 within the prison on that day. Throughout March, he complained of pain in his legs and was regularly seen by the nursing staff and had two care plan reviews. On 20 March, he attended hospital for an angiogram (which allows a doctor to look inside the coronary arteries and find out where and how severe any narrowed areas are). However, he returned to the prison the same day without the procedure having taken place. It is not clear why this was the case.
26. On 29 March, the man again complained of pain in his leg and asked that his foot be amputated. Two days later, he was admitted to hospital and, on 1 April, his right leg was amputated above the knee. He contracted an infection in hospital and, on 9 April, was moved to Ward D18 for isolation and given oral antibiotics. Following an angiogram on 18 April, he was discharged from hospital. Prison staff spoke to him about the need to keep his cell clean and not to share items with other prisoners in order to reduce the risk of infection.
27. On 13 May, the man tested positive for Methicillin-Resistant Staphylococcus Aureus. (MRSA - infection with MRSA bacteria mainly occurs in people who are already ill in hospital and can be difficult to treat as MRSA bacteria are resistant to most types of antibiotics.) Nurse A noted that he had tested positive for MRSA in his wound, that he was resistant to flucoxacillin (an antibiotic) and was sensitive to meropenem (another antibiotic used to treat a wide variety of infections). The doctor and inpatient ward manager were informed.
28. Five days later the Head of Healthcare discussed the man's condition with a microbiologist. She noted that he seemed well and active and that no MRSA treatment was required unless he became very unwell or developed an infection. It was noted that he would continue to have anti-staphylococcal dressings for the time being.
29. The man continued to be assessed by healthcare staff every day and they monitored his blood pressure, blood glucose level and wounds. His health and well being and medication, were under constant review which is reflected in the medical notes.
30. The man attended hospital on 5 August as an outpatient for a vascular surgery review. A further admission was arranged for an angioplasty (a technique of mechanically widening narrowed or obstructed blood vessels), so opening them up to improve the flow. The angioplasty took place at hospital on 3 September and he returned to prison the next day.

31. On 12 September, the man complained of pins and needles down his right side and was taken to the accident and emergency department by taxi. It is unclear what treatment, if any, was given there. He continued to complain about the pain and, on 27 September, reported that he had severe pains in his chest. The pain in his legs continued and on 20 October, it was noted that he had a chest infection and that his phlegm contained blood.
32. Two days later, a lump was found on the left side of his neck and the man was seen by a doctor. On 26 October, he fell out of his wheelchair while he was asleep and said that he had difficulty swallowing. He was seen by a doctor who referred him to the ear, nose and throat clinic as a matter of urgency.
33. The next day, the man had severe diarrhoea and was later found on the floor of his cell after again falling out of his wheelchair. He had been incontinent. An ambulance was called and he was kept in the medical assessment ward overnight at the hospital. The following day, he was moved to the surgical assessment unit. On 29 October, staff at the hospital raised concerns that three prisoners from Birmingham had tested positive for MRSA and asked for escort staff to be swabbed. (There is no further information on what action was taken by the prison, if any.)
34. On 30 October, the man had a blood transfusion and it was noted that doctors intended to amputate his left leg above the knee when he was fit enough. The operation took place on 7 November. A day later, doctors were concerned about a growth on his face and neck. The growth had been there for nine to ten weeks but had grown visibly after he was admitted to hospital. On 9 November, doctors carried out a scan on the growth on his neck. It is not clear from the notes whether the results of this scan were ever received.
35. The hospital intended to discharge the man on 13 November but, as the prison was concerned about receiving him at the weekend, he did not return to the prison until 16 November. On his return to prison, as he was a double amputee, he was unable to transfer himself from his wheelchair to the toilet or his bed. Staff manually lifted him when necessary.
36. The man was sore and again incontinent following his discharge from hospital. The results of the x-ray taken on 5 November were received by the prison on 18 November which indicated the presence of a tumour. Prison Doctor A, a doctor at the prison, spoke to him later that day to inform him that the x-ray suggested that he might have cancer. He did not appear to be shocked by this news. The doctor said that he could talk to him anytime about this. (It is unclear what treatment or further diagnosis he received for the cancer.)
37. On 19 November, the man was assessed by three occupational therapists. A sliding board was brought in to assist him to transfer to and from his wheelchair and a long seat sling was ordered to assist him getting into the shower and bath. The therapists were surprised that he had been discharged from hospital as they had not assessed him before he returned to prison. On 20 November, Nurse B contacted a nurse at hospital about his discharge. She was concerned that he had not been assessed prior to discharge, but she was told that the hospital thought he had been. She also requested his wound and treatment charts. However, the person she spoke to was unsure whether she could release this information, and would need to check. It is unclear from the medical records whether the information was ever received.

38. The man suffered from several bouts of incontinence after his discharge from hospital and from pressure sores on his buttocks. Nurse C noted in the medical records on 19 November that he needed to discuss access to his cell as staff had to go in at least twice during the night to check and change him as necessary. A risk assessment was carried out on 26 November and it was agreed that his cell door could be left open to allow easy access during the night.
39. On 25 November, the man told one of the nurses that, while he had coped with the amputations, the news of the cancer had affected him. It is not clear from the medical notes whether he had been able to speak to anyone about this. The next day, he again suffered from bouts of diarrhoea and was told to take plenty of fluid, but he did not improve. He was sent to hospital on 27 November as his blood pressure and blood sugar was low.
40. While at hospital, the man had an ultra sound which showed that he had a fracture to the right thigh bone (known as the femur neck). It was not clear how this injury had occurred or how old it was. The prison, in the meantime, carried out a risk assessment. It was agreed that he should not wear restraints such as handcuffs, but that his wheelchair should be left outside of the hospital room so that he was not independently mobile.
41. The man's health continued to deteriorate. By 11 December, he was being given oxygen and it was noted that his prognosis was poor. The prison informed his next of kin that he was very unwell. Two officers were on bedwatch during 12 December. (During a bedwatch, members of prison staff stay with a prisoner, and often use restraints to ensure there is no chance of an escape. They did not use restraints for him as he presented a very low risk of absconding.)
42. As the morning progressed, the man's breathing became weaker and shallower and at 1.30 pm, the officer thought that he had died. Officer A went to get a nurse who took readings and checked whether there was a pulse before confirming that he had died. The officers stayed with him in the side ward for about an hour and Officer A notified the prison that the man had died. The duty governor and the Care Team Leader then attended the hospital and released the two officers from bedwatch. A senior nurse certified death at approximately 3.00pm that afternoon.
43. After she returned to the prison, the duty governor telephoned the man's step-daughter, to inform her of his death. His step-daughter was out, but returned her call later that day and accepted the offer of a visit. The duty governor and a Senior Officer (SO) visited the family that evening and explained what had happened to him. His step-daughter said that she would inform the rest of the family. The duty governor explained the funeral arrangements and asked if the family wished to be involved or wanted the prison to deal with it. His step-daughter said that she wanted the prison to make the arrangements.
44. A Principal Officer (PO) was appointed as the prison's liaison officer. He looked through the paperwork on the man and saw that he had been married before. The PO sought the approval of the Governor, and then visited the man's ex-wife to inform her of the man's death as she was noted as his next of kin. The PO was unaware that the step-daughter had told the duty governor that she would tell her mother as she was concerned about her age and that she would be upset. (As it was, the man's ex-wife was already aware of his death so the PO explained the process and about funeral expenses and left contact details in case she wished to speak to them.) The following day the man's step-daughter telephoned him to say she wasn't happy that he had contacted her mother as she, the step-daughter, had requested to be the contact point.

45. A post-mortem was held on 16 December at the Central Mortuary. The cause of death was noted as carcinomatosis, due to carcinoma of the right upper lobe bronchus (lung cancer). It was also noted at the time of his death, that the man had peripheral vascular disease, a fractured right neck of his femur and diabetes.
46. The prison arranged and paid for the funeral. They also returned the man's property to his family. His ashes were scattered at the memorial gardens at the crematorium.

ISSUES

Medical care

47. The man had been ill with diabetes for a long time when he first entered prison. For the next two years the prison staff attended to his leg ulcers and various other ailments on an almost daily basis. He was referred to hospital many times to better manage his condition and to attempt to cure his leg ulcers, improve his circulation and ease his pain. There is clear documentation to show that the prison staff did all they could to keep abreast of his medical and surgical care. The number of hours spent caring for him should be noted as an example of good clinical practice.

Risk assessments

48. Once the man's condition deteriorated after his legs were amputated and he was discovered on the floor of his cell, a risk assessment was carried out. It was decided that his cell should be left open 24 hours a day so that nurses could gain quick access to him. His cell was close to the nurses' station. The risk assessment was to be reviewed every seven days. I am pleased to note the proportionate response to his condition.

Use of restraints

49. The man frequently went to outside hospital as part of his medical care. When his health deteriorated after his double amputation (and he was thought to be suffering from cancer) he returned to hospital on 27 November. A risk assessment was carried out and the only restraint was an escort chain as he was in a wheelchair and not independently mobile.
50. A further assessment was carried out on 28 November once the man was in hospital. Due to the nature of his crime and the perceived risk to children the restraints were maintained. The following day, having discussed his situation with the Governor and following concerns by medical staff about swelling in his arm, the cuffs were removed. The wheelchair was placed outside the ward at night.
51. I am pleased to note that the use of restraints was reviewed quickly after medical staff raised concerns. However, given the man's condition, I am surprised that these were considered necessary to prevent him absconding or offending while in hospital. I do not make a recommendation on the matter, as risk assessing is a complicated decision making process, but I would encourage the Governor to bring this case to the attention of his staff as restraints may well have been unnecessary.

The man's fractured femur

52. When the man was in hospital in December 2009, he had an ultrasound scan which showed that he had sustained a fracture to his right thigh. It is not clear how or when this fracture occurred and whether it was as a result of one of his falls from his wheelchair whilst in prison. He did not complain of pain in his thigh at any point.

Diagnosis of cancer

53. During his time in hospital at the beginning of November 2009, the man had an x-ray. He was released from hospital on 16 November. At 1.25pm on 18 November, the prison received the results of the x-ray from the hospital. Due to a lock down, when all prisoners are confined to their cells, the doctor was unable to speak with him until

3.28pm when he was informed that he might have cancer. He did not appear to be surprised by this and said that he had suspected it for some time. Had the results of the x-ray been available prior to 16 November, he need not have been discharged from hospital. He was sent back to hospital on 27 November although this was a result of his general deterioration rather than because of the results of the x-ray.

54. Although the x-ray did not confirm the diagnosis, the cause of the man's death was attributed to cancer. By the time the results of the x-ray were known he was already in poor health and no further tests or treatment were appropriate.
55. The clinical reviewer found that despite the prison nursing staff raising concerns about the presence of a mass in the man's neck, this was not identified by the hospital and he was released and returned to the prison. This matter is outside my terms of reference and the PCT may wish to explore it further.

Contact with the next of kin

56. At the family's request, the man's step-daughter was the designated next of kin for him. The governor on duty when he died telephoned her on 12 December and spoke with her later that day. She visited the step-daughter with a Senior Officer that evening. She informed her of her step-father's death and the funeral arrangements. The step-daughter informed her that he had brothers and sisters who she would inform even though they might not be interested. She also said that she would prefer to inform her mother herself (the man's ex-wife) because of her age and frailty and the effect this news may have on her.
57. A few days later, a PO, a family liaison officer at HMP Birmingham, returned from leave. He spoke to another PO, the manager of the Safer Custody department (a department which deals with the safety of prisoners, including prisoners who attempt to harm themselves), about the man and collected the documentation which said that he had an ex wife. They felt that she should be informed of his death and therefore agreed with the Governor that they should visit her. They were not aware that his step-daughter had told the duty governor that she would inform her mother herself. Both POs visited the man's ex-wife and informed her of his death, although she was already aware. They then explained the process and left their contact details.
58. The following day, the family liaison officer received a telephone call from the man's step-daughter who was concerned they had visited her mother, given her specific request to be the only point of contact for the family. She explained that it had caused her mother unnecessary stress and confusion.

The Governor should ensure that the named point of contact is the only person informed of a death in custody and there is clear communication between all staff responsible for this role to ensure the next of kin's wishes are respected.

Medical records

59. The man's medical record is over 200 pages long and has entries on almost every day he was in prison, often with several entries each day. Despite this there is one period where events seem to be confused.
60. In his clinical review, the Clinical Director states that on 4 February 2009, the man was seen in the Vascular Clinic at hospital and it was noted that he had pain in his leg prevented him from sleeping. A letter from the hospital suggested he needed an urgent angiogram and angioplasty and the anastomosis (connection between blood

vessels) for the leg wound. There is no corresponding entry in the prison medical records for 4 February or any time afterwards. While I make no formal recommendation in this regard, I would remind the Head of Healthcare of the importance of accurate record keeping.

CONCLUSION

61. The man had a history of heart disease as a result of diabetes, compounded by hypertension and smoking. Over a two year period, and in collaboration with the hospital, attempts were made to improve the circulation to his legs, but this was unsuccessful and he required two amputations.
62. The Clinical Director was concerned that a chest x-ray taken at the hospital on 5 November, and displaying abnormal results, was not relayed to the man until he returned to the prison some two weeks later. However, the Clinical Director concluded that this delay would not have altered the outcome of his death.
63. I have found that the prison staff showed great care and compassion for the man. They attempted to ease his discomfort and monitored and attended to him every day. They carried out a risk assessment to ensure that staff could gain immediate access to his cell in an emergency, and whilst he was in hospital assessments were made to determine whether he should wear restraints.
64. The two recommendations stem from the quality of medical reports. Whilst the records were generally well maintained, some important information was omitted. Greater care should also be given to ensuring that staff who liaise with families communicate effectively with each other.

RECOMMENDATIONS

1. The Governor should ensure that the named point of contact is the only person informed of a death in custody and there is clear communication between all staff responsible for this role to ensure the next of kin's wishes are respected.

The Prison Service responded to this recommendation as follows:

"As it stands the recommendation asks that the Governor ensures that the named contact is the only person informed of a death. This goes against the national policy contained in PSO [Prison Service Order] 2710 which advises that, where possible, all parts of a family are kept informed. It also contradicts previous recommendations made by the PPO which asked that all branches of a family are involved."

I have taken this comment into account while finalising this report. The essence of family liaison is set out at section 3.2 of chapter 4 of the PSO. It states, "Every family is different and has its own dynamics. A Family Liaison Officer needs to be flexible and open-minded and should approach the family in accordance with its individual needs". The PSO, at section 3.4 goes on to say that:

"The family may be large, split geographically, at odds amongst themselves. Many modern families are split by divorce or separation and there may be several branches all with equal rights to information. A Family Liaison Officer may be able to get the family to nominate a single point of contact who undertakes to keep other family members up to date. This may not always be possible, or may not work in practice, so the Family Liaison Officer should be prepared to deal with different sections of one family if necessary."

In this case the man's step-daughter specifically asked that she be the only point of contact, due to her mother's age and frailty. This is a different situation than when a family has several different branches who might not be in contact with each other, when it might be proper for the prison to maintain contact with each branch in an appropriate manner. In this instance, it was the wish of the family that contact be directed through his step-daughter, and Birmingham agreed, only to then contact another member of his family directly. The recommendation seeks to raise awareness about meeting the individual needs of a family and ensuring these are effectively communicated to staff who are likely to come into direct contact with the family.