PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

# A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

**Investigation into the death of a man in September 2012 at HMP Forest Bank**

## *Our Vision*

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

This is the investigation report into the death of a man in September 2012, at HMP Forest Bank. He was 41 years old and died as a result of testicular cancer which had spread to other areas of his body. I offer my condolences to his family and friends.

A review was conducted into the man's clinical care. Forest Bank cooperated fully with the investigation. I apologise for the delay in issuing this report.

When he arrived at Forest Bank in July 2012, the man explained that he had been treated for cancer and healthcare staff arranged for his secondary care to continue. In September, his oncologist found that the cancer had spread and was incurable. Shortly after this diagnosis, his condition quickly deteriorated and he moved to the prison's inpatient unit for palliative care. He did not wish to go to hospital or a hospice and he was not eligible for release on compassionate grounds.

Overall, I am satisfied that the man received an adequate standard of care at Forest Bank and the prison's healthcare department has developed good partnership arrangements with a local hospice and other community providers as a result of this case. However, I am concerned that he was inappropriately restrained during outpatient appointments and for much of his time as an inpatient. I am also concerned that the prison failed to notify his ex-partner of his death, although her contact details were noted in prison records. Even after being given his ex-partners' details by the funeral director, it was several days before the prison finally contacted her to offer information and support.

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.

**Nigel Newcomen CBE**
**Prisons and Probation Ombudsman** **March 2014**

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## SUMMARY

1. The man was diagnosed with testicular cancer in 2010 and had received extensive treatment before he went to prison on 24 July 2012. He told reception staff about his condition and his treatment continued.

2. A scan at the hospital on 13 September showed that the man's cancer had spread. At a follow up appointment on 18 September, his oncologist told him that his condition was terminal and that his treatment would be palliative. His secondary care was then transferred to another hospital.

3. Less than a week later, on 24 September, the man's condition worsened and he moved to the prison healthcare inpatient unit, where staff were better able to administer his medication. They cared for him in consultation with staff from a local hospice and a visiting district nurse. His condition deteriorated rapidly and he died a few days later with a member of the chaplaincy at his side.

4. The recurrence of the man's cancer was diagnosed promptly and he was given full information about his condition and treatment. Clinical staff at Forest Bank, assisted by hospice and community health staff cared for and supported him well. However, the investigation found that some hospital appointments were not recorded and neither were the reasons for cancellation of one appointment. A letter from his consultant indicated that this was because of a lack of escort staff.

5. During outpatient hospital appointments and an inpatient admission to hospital in September, the man was escorted by three officers and double handcuffs were used. An escort chain was used for diagnostic tests and use of the toilet. We do not consider that this level of restraint was justified, or took proper consideration of his privacy and right to confidentiality during consultations and medical procedures.

6. Although the details of the man's next of kin, his ex-partner, had been properly recorded when he arrived at the prison, staff did not look for them and relied on hearsay that he had no next of kin. His ex-partner was notified of his death by the police two days later. Despite the prison being advised by the funeral directors of the ex-partner's details, it still took the prison four days to contact her, 11 days after his death.

7. Overall, the man's clinical care was good. However, the investigation has identified a need for some improvements in the provision of end of life medication and facilitating hospital appointments. We consider that his next of kin was poorly served by the prison after his death and the use of restraints was not fully justified, particularly during tests and consultations. We have made recommendations about these matters.

## THE INVESTIGATION PROCESS

8. Notices announcing the investigation were issued to staff and prisoners, inviting anyone who might have information about the man's death to contact the investigator. Two prisoners asked to see him.

9. The investigator first visited Forest Bank on 9 October 2012. An operational manager gave him a full briefing about the circumstances of the man's death and he visited different areas of the prison, including the healthcare department where he died. He met the Chairman of the Independent Monitoring Board.

10. On 11 December, the investigator returned to the prison and interviewed two members of staff and spoke informally to the two prisoners who had asked to see him.

11. Forest Bank provided copies of the man's prison and medical records. A clinical reviewer carried out a clinical review on behalf of Salford NHS Primary Care Trust.

12. One of the Ombudsman's family liaison officers spoke to the man's ex-partner, his next of kin, to tell her about the investigation and offer the opportunity to raise any issues that she wished to be considered during the investigation. She raised the following:

    - He had been concerned about his cancer returning and access to his hospital consultant. He had missed an appointment scheduled for three days after he went into prison.
    - The police had informed her of his death two days after he had died. She wanted to know why prison staff had not contacted her first and why his next of kin details had not been recorded.

13. The investigation has assessed the main issues involved in the man's care including his diagnosis and treatment, liaison with his family, his location and security arrangements, whether compassionate release was considered and whether appropriate palliative care was provided.

14. We regret the delay in issuing this report. This was due to a backlog of investigation reports which we are striving to clear.

## HMP FOREST BANK

15. Forest Bank is a local prison in Salford, holding more than 1,364 prisoners. It holds remanded and sentenced male adults and remanded young offenders from courts in the North West. The prison is privately managed under contract by Sodexo Justice Services.

16. Primary care services are provided by Sodexo. There is a 20-bed inpatient unit with 24 hour nursing cover. Prison doctors are provided by a GP agency. Doctors are available from 9.00am to 9.00pm Monday to Friday, 1.00pm to 5.00pm Saturday and 9.00am to 12.00pm Sunday. There is out of hours cover at other times.

### HM Inspectorate of Prisons (HMIP)

17. HMIP conducted an unannounced inspection of Forest Bank in October 2012. Inspectors reported that there had been significant investment in palliative care services, including a palliative care suite. A palliative care team had been established and they used the Liverpool Care Pathway for end of life care.

### Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB) made up of volunteers from the local community who monitor standards to help ensure prisoners are treated fairly and decently. In its most recently published annual report for 2012, the IMB noted that some money had been obtained from the King's Fund to refurbish accommodation for seriously ill prisoners who needed extra care and that four nurses had been trained in the use of the Liverpool End of Life Pathway. More broadly, the IMB commented that prisoners had good access to nurses and doctors, who could see them at short notice.

### Previous deaths at Forest Bank

19. There have been three deaths from natural causes at Forest Bank since 2012. In this report, we have repeated previous recommendations to the prison about risk assessments, end of life care and family liaison.

## ISSUES

### The diagnosis of the man's terminal illness

15. The man was remanded into prison on 24 July 2012, after being charged with a sexual offence. He was convicted three days later but at the time of his death was still unsentenced. In 2010, before he went to prison, he had been diagnosed with testicular cancer for which he had received extensive treatment, including high dose chemotherapy. A CT scan in May 2012, had shown an excellent response to the chemotherapy.

16. When he arrived at the prison, the man told healthcare staff about his condition. A prison doctor assessed him the same day and subsequently spoke to his community and hospital doctors. Healthcare staff contacted his community GP the next day to obtain his medical records and wrote to his consultant oncologist to confirm his diagnosis, history and required medication. The consultant provided his history and previous treatment and the prison arranged for his treatment to continue.

17. The man attended an outpatient clinic on 28 August and the oncologist requested further tests, including a CT scan, which took take place on 13 September. (In the meantime, during a hospital admission on 3 September, for a different ailment, a CT scan had revealed that the cancer had spread.)

18. In correspondence with the prison dated 10 September, apparently about an appointment on 30 August, the oncologist mentioned that an appointment for a CT scan had been cancelled due to a lack of available escort staff. The doctor emphasised the importance of attending such appointments and that missing them could compromise the man's care. There is no record in his medical notes that an appointment for a CT scan had been scheduled and cancelled. Neither is there any reference to the appointment with the oncologist on 30 August. His ex-partner believes that an appointment had been scheduled for 27 July, but there is no reference to this in his medical records. The clinical reviewer noted that the scan was re-arranged and that when it took place, two weeks after the original appointment, it revealed the progression of his cancer. She considers that it was unlikely that the delay made any difference to the outcome for him, but we note the consultant's concern about the possible implications of such cancellations.

19. At a consultation on 18 September, the oncologist found that the man had lost weight and had complained of increasing back pain. The results of the further CT scan on 13 September showed that the cancer had spread rapidly to the liver and peritoneum (the membrane around the lower intestine).

20. The man was fully aware of his initial diagnosis of cancer before his imprisonment. He attended an appointment with his consultant a month after he went into prison and was told, three weeks later, that his cancer was terminal. We are satisfied that the prison contacted his GP and consultant, promptly about his ongoing care. While there is does not appear that the

apparent missed appointment unduly delayed his diagnosis we make the following recommendation:

**The Director and Healthcare Manager should ensure that all hospital appointments are entered in prisoners' medical records. Appointments should be cancelled only in the most exceptional circumstances with full reasons documented when this happens.**

## Informing the man about his condition and treatment

21. The man had received extensive treatment in the community for his initial diagnosis of testicular cancer. Further tests were conducted after he went into prison and on 18 September, the oncologist told him that his cancer had progressed rapidly and that treatment was likely to be palliative. After that meeting, he transferred his care to another doctor at a different hospital, as it was closer to Forest Bank.

22. The day after his appointment with the oncologist, prison nurses spoke to the man about the diagnosis and arranged an appointment with a Macmillan nurse and a visit from the prison chaplain. A doctor also saw him that day and arranged for his solicitor to be contacted about the diagnosis.

23. Doctors and a Macmillan nurse reviewed the man at hospital on 21 September. They discussed his condition, prognosis and options for palliative treatment. He decided that he did not wish to continue with any treatment. The nurse contacted the healthcare team at the prison to discuss his condition and told them that she was available for advice about his care. He was also referred to a hospice, a community end of life facility.

24. We are satisfied that the man was appropriately informed of his terminal diagnosis and his treatment options.

## The man's medical appointments and treatment

23. The man's outpatient visits began a month after he arrived at the prison. He initially attended appointments at hospital. He was transferred to another hospital when his condition became terminal.

24. The investigation has shown that the man was under the care of appropriate medical professionals and that, apart from the apparent missed appointment referred to in the diagnosis section, communication between the prison and hospitals was generally good. After his terminal condition was diagnosed, he decided against any further treatment so had no further hospital appointments.

## The man's pain relief and medication

25. When the man first went to prison, one of the prison doctors noted his history and prescribed for medication for the first night. He then spoke to his community GP to confirm his condition and medication and prescribed accordingly. The doctor also spoke to those responsible for his secondary care

to establish what medication would be appropriate in the secure environment of a prison.

26. The man had reported longstanding back pain as well as continuing painful neuropathy (nerve damage) which doctors attributed to his original cancer and chemotherapy treatment. The oncologist arranged an appointment at the pain clinic on 7 September.

27. The man was prescribed MST (long acting morphine tablets) twice a day and oramorph for breakthrough pain, the dosage to be increased as required. He also received medication for nausea, restlessness, anxiety and constipation. Healthcare staff also consulted the clinicians at the hospice about his pain management.

28. On 23 September, the man was unable to go to the medication hatch to collect his medication due to severe abdominal pain. A nurse visited him and explained that she could not take his medication to his cell at that time. (In order to dispense controlled medication on a residential wing, nurses are required to wait until all prisoners are locked in their cells, then deliver the medication in a secure box, escorted by a prison custody officer.) The nurse arranged for the GP to see him that morning. He then went to the hatch for his medication.

29. When the doctor reviewed the man later that morning, he noted the main issue was pain relief at night and therefore increased the level of oramorph. As his pain increased and more management was required, he moved to the induction unit, where there was better access to medication. He later moved to the prison's inpatient unit when the management of his pain required greater staff intervention.

30. The clinical reviewer is satisfied that staff at Forest Bank prescribed the correct medication after consulting the man's community doctor and consultant and that, while there was some problem with end of life medication (see palliative care section), he was given sufficient medication to manage his pain.

**The man's location**

31. The man initially lived on the vulnerable prisoners' wing for prisoners who might be at risk from others because of the circumstances of their offence. After seeing the doctor on 23 September, he moved the same day to an induction unit for prisoners undergoing treatment for drug and alcohol abuse. This assisted the dispensing of his medication, as the cell doors in that wing have hatches through which staff can pass medication day or night. However, his condition deteriorated quickly and the next morning, 24 September, he was admitted to the inpatient unit in the prison's healthcare centre.

32. On 25 September, the man told staff from the hospice that he did not want to transfer to hospital or a hospice but wanted to remain at the prison for his end of life care. He reiterated this to both prison and hospice staff in the following days. On 27 September, his condition worsened and he needed more care so

he was moved from a cell in the inpatient unit to a ward. He remained in the ward with constant nursing care until his death.

33. We consider that the man's accommodation needs were appropriately met as his health deteriorated. Staff respected his wishes about where he felt most comfortable and fully involved him in the decisions.

**Palliative care**

34. Once it becomes evident that a serious medical condition will not be responsive to active treatment, a palliative care plan should be put into place. The purpose is to help carers to plan when and how care will be delivered, and to help the patient make choices about how they are cared for towards the end of their life.

35. When the man moved to the healthcare wing on 24 September, prison staff began documenting his "care pathway for end of life", an assessment of his physical, psychological and spiritual needs but it was incomplete. Prison nurses contacted the hospice to seek advice about his pain management and difficulty swallowing. The next day, a doctor, a Macmillan palliative care nurse from the hospice and a community district nurse visited Forest Bank to discuss with him and healthcare staff his palliative care. They reviewed his medication and advised an increase in his morphine dosage and that it should be reviewed daily. They also completed a full assessment and care plan in consultation with him and recorded it in documents brought in by the community nurse.

36. On 27 September, as the man had deteriorated further, prison medical staff started end of life care, supported by the hospice and community services. The district nurse brought a syringe driver (an electronic device to deliver a constant regulated supply of medication directly to the patient) for staff to give him analgesics and other end of life drugs. The doctor prescribed the relevant drugs to be used with the syringe driver but they were not in stock at the prison and were delivered the next day.

37. After discussion with a doctor, the man decided he did not wish to be resuscitated in the event of cardiac or respiratory arrest. The prison did not have a policy or an appropriate form to register this but the doctor drew up an advance directive confirming his decision and that he understood the implications. It was signed by him and the doctor, and witnessed by a nurse. The doctor was satisfied that he had the mental capacity to make that decision. Forest Bank advised the clinical reviewer that since his death, they have developed a 'do not resuscitate' policy.

38. As the syringe driver had not been set up on 28 September when the man's pain increased and he became distressed, a doctor prescribed alternative drugs to calm him and make him comfortable until the syringe driver could be set up by the district nurse. Sadly, he died sitting in his wheelchair before that was done. A prison chaplain was with him when he died.

39. Prison healthcare staff consulted hospice and community specialists when necessary about the man's end of life care. We are pleased to note that since his death, the staff have used the experience gained in caring for him and developed close links with both the hospice and Salford community services, who support and provide end of life training in the care and management of patients with complex needs.

40. While we are satisfied that the man's condition was properly monitored and he was prescribed adequate medication, this would have been more effective had anticipatory end of life drugs been stocked to deliver by the syringe driver. We understand that the Primary Care Manager told the clinical reviewer that, since his death, they have arranged for the prison pharmacy to stock end of life drugs to prevent any delay in similar circumstances. Nevertheless, because of the importance we make the following recommendation:

    **The Healthcare Manager should ensure that anticipatory end of life medication is stocked at an appropriate point for patients subject to end of life care.**

**Risk assessments, escorts and use of restraints**

41. The Prison Service has a duty to protect the public when escorting prisoners to hospital, and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes into account factors such as the prisoner's health and mobility. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape and the risk to the public in the event of an escape posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion regarding the prisoner's ability to escape must be considered as part of the assessment process. It deemed that restraining by handcuffs of a prisoner receiving chemotherapy (and by implication, other life saving treatment) was degrading and that such restraint would be likely also to be regarded as inhumane unless justified by other relevant considerations.

42. The man was convicted on 27 July, for serious offences against a child and was subject to public protection measures. When he was first remanded, his security category was unclassified but staff had noted in his prison record that he was potentially category A (the highest level of security).

43. The consultant oncologist wrote to the Director of Forest Bank to express concerns about the lack of compassion and sensitivity by three escort staff at an appointment on 30 August. (The letter was dated 10 September, but handed to escort staff on 18 September.) She had found it very difficult because the consultation included intimate examinations and discussions of sensitive information and she described the man as "a very sick man who was extremely distressed". There is no evidence of a response to her letter.

44. On 3 September, the man was admitted to hospital as an emergency and was diagnosed with a urinary tract infection. The duty manager completed a risk assessment instructing that he was to be escorted by three officers and double handcuffed at all times. The handcuffs were not to be removed for either medical treatment or an emergency without prior permission by the prison duty manager. Double handcuffing entails the prisoner having his hands cuffed in front of him and having one wrist attached to a prison officer by an additional set of handcuffs and is usually required for category A or B prisoners in good health. The risk assessment included a section completed by the healthcare department, which indicated there was no objection to him being handcuffed during medical examinations.

45. The escort records show that the man spent most of his time in hospital, double cuffed to an officer even when he was in bed. This was excessive and inappropriate. An escort chain was substituted for a ten-minute period on the evening of 3 September, to allow blood to be taken and on four occasions during 4 September, to allow him to use the toilet and have a chest X-ray. (An escort chain is a length of chain with a handcuff at each end, one attached to the prisoner and the other to the officer.) The escort chain was used again on the morning of 5 September, to allow him to wash and use the toilet. It was during this admission that a CT scan was undertaken that indicated his cancer had spread. After a review of the risk assessment on the afternoon of 5 September, the escort was reduced to two officers and an escort chain. He was discharged on 6 September. He subsequently attended several outpatient hospital appointments in September, for which the risk assessment specified that he should be double cuffed, or with an escort chain during treatment.

46. The man's wing and security assessments show that he was compliant and had not presented any behaviour or security problems at court or in hospital. It appears that his offences alone were the major determining factors of the high level of security for the escort with little regard to the likelihood of an escape or evidence that the risk assessments were conducted in line with guidance issued by the Prison Service after the High Court judgement.

**The Director should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances, including the need for privacy during medical examinations and are based on the actual risk the prisoner presents at the time.**

**Liaison with the man's family**

47. Prison Rule 22(1) states:

Notification of illness or death

> "If a prisoner dies, becomes seriously ill, sustains any severe injury or is removed to hospital on account of mental disorder, the governor shall, if he knows his or her address, at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may

reasonably have asked should be informed."

48. When he arrived at Forest Bank, the man nominated his ex-partner as both his next of kin and emergency contact. Staff entered her address on his personal summary sheet as well as his electronic records. His correspondence file indicates that he wrote to his ex-partner 13 times between 30 July and 19 September. His telephone account also shows that he called her 163 times between 26 July and 9 September, although he did not get through every time.

49. On 25 September, the man told the hospice palliative care nurse that he had not had contact with his father for many years and would like to do so before he died. At a further care meeting the next day, he raised the issue again. Staff gave him the contact details of the Salvation Army and advised him to write to them with all known information.

50. A chaplain at Forest Bank is also the prison's family liaison officer (FLO). He received a telephone call at home at around 6.30am on 28 September, to advise him that the man's health was deteriorating rapidly. Although he had started a period of annual leave that day, he immediately went to the prison. He asked the nurses about the man's next of kin and was told that he had none. He could not recall specifically who told him. He then telephoned the prison's security department at around 8.00am, to find out whether any contact numbers were available from his telephone account. The security officer said there were two and gave the names of two women. The officer added that the man had tried to telephone both of them but the calls had never been connected.

51. A short time later, the FLO asked the man if he should contact anyone. He asked for his father to be informed and gave a telephone number (he did not know the address). After ringing the number several times, the person who eventually answered said the person was not known at that address. The FLO told him that he had not been able to contact his father. Before he left the prison to resume his leave, he updated the performance manager and the deputy family liaison officer, as well as the prison's Head of Residence. At that time the chaplain was the only trained FLO at the prison.

52. The performance manager noted in the duty officer's log that they had been unable to contact the man's next of kin. She also spoke to the police, who attended the prison later that afternoon. The prison made no further effort to contact his next of kin but the police traced his ex-partner on 30 September and told her that he had died.

53. A Security Information Report (SIR) about the man's death was submitted on 28 September and the next day, the performance manager noted on the SIR that there was "No NoK". The Governor's comments/actions section was marked, "As above" and signed by a manager, endorsing her entry.

54. On 4 October, the funeral director telephoned the prison and told the performance manager that the man's ex-partner, his next of kin, had contacted them to arrange his funeral. She did not then contact the ex-partner but noted

in the family liaison log that she would speak to the FLO about contacting her and that she thought the relevant telephone number was on the man's prisoner telephone record. She informed the FLO when he returned to duty on 8 October, four days later.

55. The FLO confirmed the information with the funeral director and immediately telephoned the man's next of kin, who told him she was his ex-partner and that they had two children together. He offered his condolences, told her that the prison would meet the cost of the funeral and offered the opportunity to visit the prison. The FLO contacted her again on 10 October, when she confirmed details of the funeral and told him she had broken the news to his father. He spoke to the man's father on 15 October, who said that he had lost contact with his son six or seven years before. The prison made no further contact with the ex-partner but, at his funeral on 18 October, the FLO returned his property to her. On 29 October, the man's father visited the prison and spoke to staff in the healthcare department about his son's care.

56. We found that the man's next of kin details had been recorded in both his paper and electronic records. There was also evidence of a large number of telephone calls. It is therefore unacceptable that prison staff did not check further and notify his ex-partner of his death immediately after it happened, when it was clear that all the information was available. It seems the family liaison officer accepted, at face value, healthcare staff's view that he had no next of kin. He was then given incorrect information from the security officer that calls had not been connected to the people named in the telephone record. The FLO was then on leave and the performance manager also accepted, without checking, the account that he had no next of kin. Even when she was informed of his ex-partner's details she did not contact her but waited a further four days for the FLO to return from leave. It was therefore 11 days after the man's death before anyone from Forest Bank contacted his ex-partner.

57. The prison had only one trained family liaison officer when the man died. The person who deputised was inexperienced in the role. Despite the lack of trained liaison officers, senior staff at the prison should have been sufficiently aware of where prisoners' next of kin details are recorded to have checked whether such details were available. Once they became aware of his ex-partner, they should have contacted her immediately. In addition to the requirement to inform families promptly of a prisoner's death, Prison Service Instruction (PSI) 64/2011 requires prisons to have procedures to engage with the next of kin of prisoners who have a terminal illness. Had this been done earlier this would have avoided the difficulties and misunderstandings after his death. We make the following recommendation:

**The Director should:**

**(i) formally apologise to the man's ex-partner for the failure to notify her of his death;**

**(ii) ensure that a suitable member of staff is nominated to engage with the families and next of kin of a prisoner with a terminal of other serious illness;**

**(iii) and ensure that there are sufficient trained family liaison officers to contact and provide effective support for bereaved families.**

**Compassionate release**

58. As an unsentenced prisoner, the man did not meet the standard criteria for early release on compassionate grounds. In any event, he expressly stated that he wished to remain in the prison.

## RECOMMENDATIONS

1. The Director and Healthcare Manager should ensure that all hospital appointments are entered in prisoners' medical records. Appointments should be cancelled only in the most exceptional circumstances with full reasons documented when this happens.

   *Accepted. Hospital appointments are scanned onto prisoners' notes. Appointments are only cancelled in exceptional circumstances or for security reasons. Reasons are documented.*

2. The Healthcare Manager should ensure that anticipatory end of life medication is stocked at an appropriate point for patients subject to end of life care.

   *We carry a full range of medication for end of life care, and have a Graesby syringe driver to deliver continuous medication.*

3. The Director should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances, including the need for privacy during medical examinations and are based on the actual risk the prisoner presents at the time.

   *All prisoners are risk assessed on an individual basis and fully take into account individual circumstances; this is documented in the escort paperwork. All prisoners are placed on the escort chain during medical examinations to ensure privacy is maintained during an examination.*

4. The Director should:

   (i) formally apologise to the man's ex-partner for the failure to notify her of his death;

   *Accepted. The Director will offer apologies to the family for the confusion over the nominated next of kin and explain the circumstances.*

   (ii) ensure that a suitable member of staff is nominated to engage with the families and next of kin of a prisoner with a terminal of other serious illness;

   *Accepted. The Family Liaison Officer will be the member of staff appointed to engage with the families and next of kin of a prisoner with terminal or other serious illness.*

   (iii) and ensure that there are sufficient trained family liaison officers to contact and provide effective support for bereaved families.

   *Accepted. There are 2 trained Family Liaison Officers at Forest Bank, with a further 2 awaiting training.*