



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at HMP
Birmingham in April 2014**

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, who died of a brain tumour on 21 April 2014, while a prisoner at HMP Birmingham. He was 57 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by an investigation. A clinical reviewer reviewed the clinical care the man received at HMP Birmingham. The prison cooperated fully with the investigation.

The man was remanded to HMP Birmingham on 28 November 2013. It was noted that he had asthma, type two diabetes and had suffered a stroke in February 2013. On 15 December, he became unwell and was taken to hospital by ambulance, where he was diagnosed with a brain tumour. The man was discharged to the prison's healthcare centre on 3 January 2014. On 8 January, he was told that his condition was incurable and he began a two week course of radiotherapy at hospital to help alleviate the symptoms of his tumour.

Although doctors had originally considered that the man might have a life expectancy of up to 18 months his condition deteriorated more quickly than anticipated and, on 9 April 2014, he moved to St Mary's Hospice in Birmingham where he died.

The clinical reviewer considers that the man received a very good standard of care at Birmingham and I agree. However, more could have been done to facilitate contact with the man's family when he became seriously ill and I am concerned that risk assessments for the use of restraints were not sufficiently thorough to justify their use on a dying man.

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

November 2014

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SUMMARY

1. The man was remanded to HMP Birmingham on 28 November 2013 charged with a serious sexual offence. His initial reception health screen noted he had type two diabetes and arthritis and had suffered a stroke in February 2013.
2. At 2.00pm on 15 December 2013, staff became concerned about the man's health. He had not collected his medication or food and had been incontinent. Nurses monitored him on three occasions throughout the day. At 5.00pm, his condition deteriorated and he was taken to Sandwell Hospital, Birmingham, where scans and a biopsy revealed a large tumour on his brain.
3. On 22 December, he was transferred to the Queen Elizabeth Hospital, Birmingham for brain surgery but not all of the tumour could be removed. The man was discharged from hospital back to prison on 3 January 2014 and was accommodated in the healthcare centre.
4. On 8 January 2014, a consultant at the Queen Elizabeth Hospital told the man that the brain tumour was incurable and the likely prognosis was around 18 months, depending on how well he responded to treatment. Nurses at the prison asked him about informing his family and he said he wanted to let them know himself. However, he had lost touch with his family and the prison did not have any contact details. On 15 January, the man moved to a specialist palliative care cell in the prison's healthcare unit.
5. On 28 January, the man began a course of eight radiotherapy sessions over a two week period to alleviate his symptoms. Restraints were used for all the man's hospital appointments and admissions but were removed for treatment.
6. The man was due to appear in court on 6 March but was not fit enough. That evening, his son contacted the prison after finding out from the court that the man had not attended because he was seriously ill. The man's son visited him on 11 March and he and other family members continued to visit him after that.
7. On 20 March, the man's condition deteriorated and he moved to St Mary's Hospice, Birmingham where his healthcare needs could be better met. His condition stabilised and he returned to the palliative care suite at HMP Birmingham on 2 April. On 9 April, his condition deteriorated again and he returned to St Mary's Hospice. The man died at the hospice on 21 April.
8. We agree with the clinical reviewer that the man received a very good standard of clinical care at HMP Birmingham, equivalent to that he could have expected to receive in the community. However, we consider more should have been done to contact his family when he became seriously ill and that risk assessments for use of restraints were not fully considered, both issues we have raised before. We make two recommendations.

THE INVESTIGATION PROCESS

9. The investigator issued notices to staff and prisoners at HMP Birmingham informing them of the investigation and inviting anyone with relevant information to contact him. No one responded.
10. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records. He interviewed one member of healthcare staff at the prison on 28 May. The investigator gave the Director of HMP Birmingham initial feedback on the preliminary findings of the investigation.
11. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.
12. We informed HM Coroner for the City of Birmingham and the Borough of Solihull of the investigation, who provided the cause of death. We have sent the Coroner a copy of this investigation report.
13. One of the Ombudsman's family liaison officers contacted the man's son, his nominated next of kin, to explain the investigation. The man's son asked if compassionate release was available for prisoners on remand and why there had been a delay in informing him that his father was seriously ill.
14. The man's son received a copy of the draft report and indicated that he was satisfied with the findings.
15. The draft report was issued for consultation with the prison service. There were no factual inaccuracies and the action plan has been added to the end of this report.
16. The investigation has assessed the main issues involved in the man's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.

HMP BIRMINGHAM

17. HMP Birmingham is a large local prison, principally serving the West Midlands courts. It holds a maximum of 1450 remand and sentenced men. Since 1 October 2011, it has been managed by G4S Care and Justice Services.
18. Birmingham and Solihull Mental Health Foundation Trust provide 24 hour health services at the prison. Primary care services are subcontracted to Birmingham Community Healthcare NHS Trust.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Birmingham was in March 2014. Inspectors noted that health services were generally very good and valued by most prisoners. However, rates of non-attendance at healthcare appointments were too high. There was a reasonable mix of daytime activities for inpatients but no education provision. External health appointments were rarely cancelled for security reasons. Inspectors noted that a palliative care room had been opened in the healthcare centre and the prison had a conventional palliative care policy.

Independent Monitoring Board

20. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its most recently published report for the year to June 2013. The IMB noted that healthcare provision was available in the prison 24 hours a day, with nurses on duty throughout the night. Doctors were on site every weekday and a locum service provided evening and weekend cover. Prisoners could usually see a GP within a week and almost immediately if urgent. The IMB noted that a palliative care cell was now available for use and appropriate for its purpose.

Previous deaths at HMP Birmingham

21. The man was the third prisoner to die from natural causes at HMP Birmingham since July 2012. We have previously raised the issue of informing families when a seriously ill prisoner is admitted to hospital and the need for fully considered security risk assessments for the use of restraints.

ISSUES

The diagnosis of the man's terminal illness and informing him of his condition

22. The man was remanded to HMP Birmingham on 28 November 2013. A nurse carried out the man's initial reception health screen and the next day, a prison GP saw him and noted that the man had type two diabetes, hypertension (high blood pressure), arthritis and had suffered a stroke in February 2013. The GP reviewed his medications and continued prescriptions for metformin and sitagliptin (for diabetes) clopidogrel (to prevent blood clots), ramipril (for high blood pressure), simvastatin (to lower cholesterol), diclofenac (anti-inflammatory pain relief) and tramadol (pain relief).
23. At 11.00am on 15 December, the nurse noticed the man had difficulty swallowing his medication and referred him to the GP to change it to soluble or liquid form. At about 2.00pm, an officer told a nurse that the man was unwell. He had not collected his medication at lunchtime, appeared confused and had vomited. His cell mate reported that the man had not eaten and was incontinent. A nurse took the man's clinical observations. His blood pressure was low but he refused to have his blood sugar level taken. She noted that he had neglected his appearance, his speech was reduced and that he was very vague. He told her that he had not eaten for seven days. His medication log showed that he had been refusing some medication. A nurse referred him for a mental health assessment.
24. A nurse assessed the man's mental health at 2.30pm and recorded that he should have a period of assessment as an inpatient in the prison's healthcare centre. However, before this was arranged, at around 5.00pm, the man's cell mate rang their cell bell and told the officer that the man had collapsed and he had prevented him from falling to the floor. A nurse attended and noted the man was vague, confused and had a fever. His blood sugar levels were high and she suspected he might have had a stroke as he had a droop to the left side of his face. He was taken by emergency ambulance to Sandwell Hospital, Birmingham.
25. The man remained in hospital and on 16 December, he had a CT scan which revealed a suspected brain tumour. On 18 December, a hospital doctor told the man that the results of the scan had showed a lesion on the brain that would require surgery. The man was transferred to the Queen Elizabeth Hospital to see a specialist neuro-consultant on 22 December. Eight days later, he had an operation to remove a brain tumour, but not all of the tumour could be removed safely.
26. The man was discharged from hospital on 3 January 2014 and admitted to the healthcare inpatient unit at the prison.
27. The man attended an appointment at the Queen Elizabeth Hospital on 8 January with a nurse to support and advise him. A consultant neurosurgeon, told the man that he had an incurable brain tumour. He explained that the typical life expectancy for someone with his condition was 18 months

depending on responsiveness to treatment. The neurosurgeon informed the prison of this in a letter dated 15 January.

28. The clinical reviewer noted that the man's symptoms developed rapidly. There was no delay in referring him to hospital, where his cancer was diagnosed. Hospital staff informed him of his condition and healthcare staff at Birmingham supported him appropriately.

The man's medical treatment

29. On 8 January, after the neurosurgeon had informed him of his diagnosis, a consultant clinical oncologist discussed his condition with the man and the possibility of radiotherapy treatment to help control his symptoms. The man agreed to have the treatment. Records show a nurse advised the man to contact his family at this time, but his response is not recorded.
30. On 8 January 2014, prison healthcare staff implemented a care plan to support the man. There was good liaison between the prison and the hospital and Macmillan nurses were consulted for specialist advice. On 16 January, a further care plan began, specifically to cover the symptoms of radiotherapy treatment.
31. Nurses monitored the man's condition daily. His medical records show that doctors adjusted his medication in accordance with the needs of his diabetes and radiotherapy treatment.
32. On 16 January, the man attended an appointment at the Queen Elizabeth Hospital cancer centre. Doctors took a CT scan and fitted the man with a face mask in preparation for his radiotherapy sessions which was scheduled to begin on 28 January.
33. On 18 January, the man told a nurse that he felt tired, unwell and had a headache. A nurse recorded that the man had a high temperature and gave him paracetamol.
34. On 21 January, a nurse noted the man had a fever and referred him to a GP. A doctor examined the man and found no new symptoms but advised further monitoring of the man's condition and requested a urine sample which was sent for testing the same day.
35. On January 24, the doctor took a blood sample from the man which indicated high CRP levels (C-reactive protein – which can be indicative of inflammation). The doctor contacted the neurosurgical unit at the Queen Elizabeth Hospital to discuss the possibility that the man had an infection as a result of his brain surgery on 30 December 2013. The next day, after further tests, the doctor referred the man to the Queen Elizabeth Hospital. The man went to hospital that evening and was treated for a urine infection. He returned to the prison on 31 January.

36. While at the hospital, the man attended daily radiotherapy sessions from the 28 January to 31 January as planned. Between 3 February and 6 February the man attended four further daily radiotherapy sessions. The man experienced memory loss and episodes of confusion as a result of the radiotherapy treatment. Healthcare staff regularly monitored his medication, food intake, sleep, mental state and general physical health.
37. On 6 March, healthcare staff began a palliative care plan (for someone with a life-limiting condition) for the man. This included frequent observations, pain relief and measures to ensure his comfort and safety.
38. The man was due to be tried at Warwick Crown Court on 6 March. On 4 March, a community psychiatric nurse, assessed the man and recorded that he was confused and disorientated. A psychiatrist assessed the man the next day. He noted that due to fluctuations in his cognitive function and ongoing problems related to the brain tumour the man was unfit to attend court. The clinical lead at the prison wrote to the man's solicitor to inform him of this.
39. On 13 March, the doctor discussed with the man whether he wanted to be resuscitated in the event of a cardiac or respiratory arrest. The doctor explained that the man's condition meant that this was unlikely to be successful. The doctor was concerned that the man had not fully understood this conversation and suggested revisiting the matter at a later date.
40. On 21 March, the man was admitted to St Mary's Hospice after his health deteriorated. On 26 March, the hospice informed the prison that the man's condition was stable and he would be ready for discharge back to the prison soon and staff began preparations. Records show that the man's understanding and communication was limited and it was not possible to speak to him about resuscitation, but clinicians decided that attempts at resuscitation would be inappropriate. The man returned to the prison from the hospice on 2 April. The doctor signed a further order noting that the man had an incurable brain tumour and that cardiopulmonary resuscitation should not be attempted as it would be likely to be futile.
41. Nurses continued to care for the man in the prison's palliative care suite until his condition deteriorated further and he returned to St Mary's Hospice on 9 April. The man died at the hospice on 21 April.
42. The coroner found that the man died of a glioblastoma (brain tumour). There was no post-mortem.
43. We agree with the clinical reviewer that the man's condition was well managed at HMP Birmingham. There were appropriate care plans in place and prison healthcare staff worked well with hospital staff and Macmillan nurses to ensure the man was well cared for.

The man's location

44. Before he was admitted to hospital in December 2013, the man lived on G wing at Birmingham. After he returned to the prison from hospital on 3 January 2014, he was admitted to the inpatient healthcare centre and did not go back to live on a wing. Clinical staff saw him every day and care was available 24 hours a day.
45. The man's condition deteriorated and he was moved to the palliative suite in the healthcare centre on 15 January 2014. This is specially designed for end of life care with room for nurses to move around the bed and specialised equipment.
46. On 18 January, the prison considered whether a move to an approved premises (formerly bail/probation hostel) would be appropriate for the man. A legal services officer at the prison discussed this with the man who stated that he would only consider somewhere in the Warwickshire area. The legal services officer contacted two approved premises on the 12 February to consider the man's suitability for placement, but neither had space available. (Such a move would have required the court to bail the man.)
47. On 18 March, clinical staff discussed hospice care with the man. A palliative care specialist nurse at St Mary's Hospice, Birmingham explained to the man that the hospice was not appropriate for him at this time as it was a more suitable place for end of life care. In her view, the man had not yet reached this stage. However, on 20 March the man's condition deteriorated significantly. He was lethargic, sleepy and his mobility reduced. The man moved to the hospice the next day and a nurse accompanied him. After the man's condition stabilised, he was discharged from the hospice and returned to the prison's palliative care suite on 2 April.
48. On 8 April, the nurse asked the hospice to readmit the man as he was unable to take fluids and appeared vacant. She noted that the hospice was likely to provide better access to his family in order to aid a dignified death. On 9 April, the man returned to the hospice and remained there until his death on 21 April.
49. We are satisfied that the man's location was appropriate throughout his illness.

Restraints, security and escorts

50. When prisoners have to travel outside prison such as to a hospital, a risk assessment is conducted to determine the nature and level of any security arrangements including any restraints.
51. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity and maintain their dignity. The level of restraints used should be necessary in the circumstances and based on a risk assessment which considers the risk of escape, the risk to the

public and which also takes account of 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 about the prisoner's ability to escape must be considered as part of the assessment process. It also 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.

52. The man was taken to hospital at 6.05pm on 15 December 2013 by emergency ambulance. A risk assessment indicated that the man was a normal risk, he should have two escorts and be restrained with a single cuff, due to his age and low risk of escape. Shortly after he was admitted to the hospital, the single cuff was removed and an escort chain was applied. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.) At 7.30pm, the restraints were removed while the man underwent a CT scan, they were reapplied afterwards. At 4.10pm the next day, a review of the risk assessment indicated no changes in circumstances. The man remained restrained by an escort chain.
53. On 18 December, one of the escort officers noted that the man was acting unusually, interfering with his restraints and spilling his drink on the floor. There is a similar entry on 19 December. Hospital staff informed the escort officer that this was due to the man's brain tumour. There is no evidence of any review of the man's risk assessment for this period.
54. At 4.05pm on 20 December 2013, records show the man inappropriately touched the hand of an officer. One of the escort officers said that earlier in the day, the man had been acting inappropriately to a female nurse at the hospital but there is no record of this. At 5.00pm, another officer cautioned the man for playing with his cuffs and acting inappropriately to female members of staff (it is not clear what inappropriate behaviour this was). At 7.10pm he warned the man again stating that double cuffs (where a prisoner's hands are cuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs) would be applied if he did not stop playing with his restraints. At 7.30pm, the officer applied double cuffs to the man and telephoned the duty manager to update him. The officer told the duty manager that the man was not being aggressive but was just being a nuisance and this was probably due to his condition. By 8.30pm, the man had become calm and settled. Escort staff replaced the double cuffs with an escort chain.
55. On 22 December 2013, the man was taken from Sandwell Hospital to the Queen Elizabeth Hospital for brain surgery. No risk assessment was provided for this transfer and there is no evidence that any review was carried out once the man arrived. The prison was unable to provide evidence of what level of

restraint, if any, was used for this escort, but it appears that he remained restrained by an escort chain during his stay at the Queen Elizabeth Hospital.

56. On 3 January 2014, the man was discharged from the Queen Elizabeth Hospital and taken back to HMP Birmingham by taxi. The escort notes do not indicate whether any restraints were used.
57. On 8 January, the man attended an appointment at the Queen Elizabeth Hospital. A risk assessment considered the man to be a normal risk of escape and to the public and the man was double cuffed. On 15 January, the man attended a further appointment at the hospital for radiotherapy. A risk assessment considered the man to be a normal risk of escape and to the public. However, it stated that single cuffs should be used because of the type of illness and his level of frailty.
58. The man's healthcare records show that the level of restraint was discussed on 22 January, at a multidisciplinary meeting involving healthcare and safer custody staff. This was in advance of the likely deterioration in his health and to appoint roles should the man require admission to hospital for his condition.
59. The man was taken to hospital by emergency ambulance on 25 January. The prison could not provide a record of a risk assessment for this transfer. The escort records indicate that restraints were used, but not the level or type of restraint.
60. Records show double cuffs were used to escort the man to and from the Queen Elizabeth Hospital for daily radiotherapy appointments between 2 February and 6 February. These were removed for treatment.
61. Where risk assessments were completed, there is healthcare input stating no objections to restraints and a box is ticked to indicate the man's medical condition did not restrict his ability to escape unaided. However, there is no further information.
62. Restraints were not used when the man was taken to St Mary's Hospice on 21 March and 9 April or returned to HMP Birmingham on 2 April. He was accompanied by two officers who remained outside the room.
63. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances which must be fully considered, taken into account and balanced against the security risks. The man was frail, confused and very ill for most of the time he was in prison. We are not satisfied that restraints were justified by fully considered or reviewed risk assessments that took into account the man's risk and condition at the time. We do not consider that healthcare staff ticking a box is sufficient to comply with the 2007 High Court judgement; there needs to be appropriately considered healthcare input on each occasion. Ultimately, it is the Director's responsibility to ensure that the process is managed properly, but the Head of Healthcare also needs to ensure that healthcare staff understand their

responsibilities and have appropriate and considered input into the risk assessment process.

64. On several occasions the man was double cuffed. This is usually required for moving category A or category B prisoners in good health. On 20 December, double cuffs were applied to the man for “being a nuisance”. This is not sufficient reason to apply double cuffs to a seriously ill and confused man in a hospital bed. Records of risk assessment were poor and some assessments were incomplete or missing. We make the following recommendation:

The Director and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time and are appropriately recorded and reviewed.

Liaison with the man’s family

65. The man was admitted to hospital on 15 December 2013. Prison Rule 22 says that if a prisoner becomes seriously ill, the Governor should “at once inform the prisoner's spouse or next of kin.” The duty governor at the time told us he did not consider contacting the man’s next of kin as he did not consider his condition was sufficiently serious and in any event there was incomplete information in the man’s record, with only the name of his next of kin recorded.
66. On 18 December 2013, a doctor at Sandwell Hospital told the man that his condition was serious and that he would require surgery. On 22 December, the man was transferred to the Queen Elizabeth Hospital, where he had an operation to remove a brain tumour. The man remained in hospital until the 3 January 2014. We could find no evidence that any attempt was made to trace the man’s family during his stay in hospital, despite the seriousness of his condition becoming clear during this time, or that anyone discussed this with the man.
67. The man was told of his diagnosis and advised to contact his family. On 10 January, a nurse spoke to the man about this and the man insisted that he wanted to inform his family but he did not have any contact details. The officer offered to help him. On 13 January, another officer contacted HMP Leicester (where the man had been in 2010) to try and obtain next of kin details, but this was unsuccessful.
68. The nurse spoke to the man again on 17 January about family contacts. The man explained that he did not keep in contact with his family and had not seen his son for some time.
69. On 21 January, a healthcare manager at Birmingham, was appointed as family liaison officer. The healthcare manager again contacted HMP

Leicester to try and obtain the man's family contact details, but they could find no records.

70. The man's son told the Ombudsman's family liaison officer that he found out about his father's condition when the man did not attend court on 6 March. He said he was upset his father had had a number of major operations without his family knowing.
71. The man's son contacted the prison on the evening of 6 March and visited his father at the prison on 11 March. The man's family continued to visit him in prison and during his stay at the hospice.
72. The man died in the hospice on 20 April. His family were not present at the time and hospice staff informed them of his death. The prison offered financial assistance towards funeral costs in line with national guidance. The funeral was held on 9 May.
73. Although the prison made some attempt to find the man's next of kin, this was limited to contacting HMP Leicester. We would have expected more active attempts to find his family, such as by contacting the police or the man's solicitor. We also consider that the prison should have attempted to trace the man's next of kin, as soon as it became clear that he was seriously ill on 18 December. This is an issue we have raised with the prison before. We make the following recommendation:

The Director should ensure that when a prisoner becomes seriously ill, active efforts are made to inform his family unless the prisoner has indicated otherwise.

Compassionate release

74. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months. Prisoners like the man who are on remand are not eligible for compassionate release and can only be released from prison if they are bailed by the court.

RECOMMENDATIONS

1. The Director and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time and are appropriately recorded and reviewed.
2. The Director should ensure that when a prisoner becomes seriously ill, active efforts are made to inform his family unless the prisoner has indicated otherwise.

ACTION PLAN

No	Recommendation	Accepted/ Not accepted	Response	Target date for completion and function responsible
1	The Director and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time and are appropriately recorded and reviewed.	Accepted	<p>The Director will ensure that prison staff are aware of their responsibilities with regards to risk assessments and ensure that any changes to the risk assessment are accurately reported and recorded.</p> <p>The Head of Healthcare will ensure that risk assessments are informed by up to date information regarding each prisoner's physical health. This will ensure that the outcomes of risk assessments are as accurate as possible when determining the risk that prisoners pose to staff and the general public.</p>	<p>1 October 2014</p> <p>Head of Security</p> <p>1 October 2014</p> <p>Head of Healthcare</p>
2.	The Director should ensure that when a prisoner becomes seriously ill, active efforts are made to inform his family unless the prisoner has indicated otherwise.	Accepted	The Duty Director of the day will make every reasonable effort to contact the next of kin or any other recorded family member once staff are aware that a prisoner has become seriously ill. A record of these management actions will be recorded in the Duty Manager's log and/or Family Liaison Record where a Family Liaison Officer (FLO) log has been initiated.	<p>1 October 2014</p> <p>Head of Safer Custody</p>