

**Investigation into the circumstances surrounding the  
death of a man at HMP Elmley,  
in July 2008**

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

**May 2009**

This is the report of an investigation into the death of a man at HMP Elmley. He died in his cell in the prison's healthcare centre on the afternoon of 12 July 2008. I offer my sincere sympathy and condolences to the man's family, and to all of those affected by his loss.

The man was in his mid-seventies when he was sentenced to five years imprisonment in 2005, and already had an extensive medical history. A post mortem examination gave the cause of death as ischaemic heart disease with a secondary condition of chronic obstructive pulmonary disease (a disease of the lungs in which the airways become narrowed).

The investigation was carried out on my behalf by one of my investigators, who was assisted by another colleague when interviewing staff at Elmley. An independent review of the man's medical care in prison was carried out by an appointed doctor on behalf of the local Primary Care Trust (PCT). I am most grateful to him for his assistance. However, due to a significant delay on the part of the PCT before the doctor was appointed as clinical reviewer, I am issuing this report much later than I would have chosen.

I would like to thank the Governor and staff at Elmley for their full and ready co-operation during the course of the investigation. I am particularly grateful for the liaison that staff provided.

I find that the man had a difficult time at Elmley. He struggled to manage his prescribed medication, and encountered problems with his mobility and with bullying. I make a total of eight recommendations.

**Stephen Shaw CBE**  
**Prisons and Probation Ombudsman**

**May 2009**

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## SUMMARY

The man was received at HMP Elmley on 22 July 2005, having been sentenced to five years imprisonment on the same day. This was his first time in custody. He had several long standing health problems including a kidney transplant, left hip replacement (as a result of which he had reduced mobility), and asthma. As a result, he was taking a number of different types of medication.

It soon became apparent that the man was having difficulty managing his medication. In January 2006, around two months worth of medication was found in his cell. His prescribing regime was therefore changed and he was given his medication in weekly blister packs (packaging that arranges tablets in rows and columns by day of the week and time).

Despite this, and the reassurance of staff, the man complained regularly that his medication was missing. In January 2007, a large quantity was again found in his cell. His regime was changed for a second time and he was now given medication on a daily basis. However, he did not like this change and saw it as a punishment. After a two month trial, he returned to weekly collections.

As well as struggling to identify the correct medication to take at the right time, the man reportedly had difficulty negotiating the stairs to the treatment hatch on his houseblock. It was also reported that he was the victim of bullying, seemingly on account of his frailty.

In early May 2008, the man reported difficulty breathing and was diagnosed with an abnormal heart rhythm. A month later, his health had deteriorated to the extent that he was admitted as an inpatient to the prison's healthcare centre. On 12 July at around 4.40pm, he was found by staff collapsed in his wheelchair. His breathing was poor and he had no pulse. A prison doctor and nurse attempted to resuscitate him, but were unsuccessful. He was pronounced dead by the doctor at 5.17pm. The cause of death was given as ischaemic heart disease with a secondary condition of chronic obstructive pulmonary disease.

Caring for the man presented staff with a number of challenges. Nevertheless, I am satisfied that the care that he received was respectful and, in the main, appropriate. However, I make a total of eight recommendations covering a variety of aspects of his time at Elmley. They include, amongst others, the recording of changes of medication, communication with outside hospitals and the investigation of incidents of bullying.

## THE INVESTIGATION PROCESS

1. The investigation was opened on 14 July 2008 when my investigator issued notices announcing the investigation to staff and to prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to my investigator. No prisoners came forward as a result.
2. My investigator was given access to the man's prison files, including the medical record. He visited Elmley on 23 September 2008 and, with the assistance of my colleague, interviewed five members of staff and one prisoner.
3. An independent clinical review of the man's health needs whilst he was in custody was carried out by an appointed doctor on behalf of the Primary Care Trust (PCT). Unfortunately, the doctor was not appointed by the PCT until mid-November 2008. The review was not therefore received at my office until 14 January 2009.
4. My former senior family liaison officer telephoned the man's sister on 31 July 2008, to inform her of the investigation. On behalf of the man's family she raised the following issues that she wanted the investigation to address:
  - The man was seen by different nurses all of the time and therefore had no continuity of care. His sister said that she had spoken to the head of healthcare at Elmley who had said she would get a named nurse to help him take his morning medication. However, this rarely happened because of staffing levels.
  - The man had problems getting the correct medication. He was sometimes given the wrong medication and, when he wrote notes asking for the correct medication, "they would laugh at him and screw up his notes". Sometimes the doctor would change his painkillers and, when it was apparent that this increased his pain, they would be changed back.
  - The man had problems with his mobility and it was therefore hard for him to get upstairs on his crutches. On one occasion he had to crawl upstairs. He was often late for visits because of the time it took for him to get to the visits hall. His sister twice asked if she could send a wheelchair in for him and was assured that one was available. However, he did not have access to the wheelchair and his sister was told that this was because there was nowhere to store it.
  - On one occasion the man fell and hit his head at around 2.00pm. However, he was not seen by nursing staff until 5.00pm.
  - The man was bullied in prison. Apparently ping pong balls were thrown at him and he was poked with pool cues. His sister suspects that this was because of his age and offence.

5. My senior family liaison officer telephoned the man's sister on 24 April 2009. She told my senior family liaison officer that the report was "full of mistakes and inaccuracies" and that her brother was "treated badly by the Prison Service". His sister did not want to expand any further on these comments and said that she would prefer to let her brother rest in peace.

## HMP ELMLEY

6. Elmley is the largest of three prisons clustered on the Isle of Sheppey. It is a local prison for all of Kent with capacity for 985 prisoners. There are five residential houseblocks plus a healthcare unit. Houseblock 4, where the man lived for most of his time at Elmley, is for vulnerable prisoners (those who are separated from the majority of prisoners because of factors such as the type of offence committed).
7. Healthcare in the prison is commissioned and provided by the Primary Care Trust. The healthcare centre includes a 29 bed inpatient unit, treating patients with both physical and mental health problems. Most patients receive their medication on a 28 day in possession basis. Those who are not deemed suitable for in possession medication collect daily from a treatment room in the healthcare centre. There is a separate treatment hatch in Houseblock 4 for patients who live on that unit.
8. Elmley was last inspected by Her Majesty's Chief Inspector of Prisons in December 2006. She found that healthcare staffing levels were "worryingly low" and that arrangements for medication were "unsatisfactory". She also found that Houseblock 4 held a number of prisoners who were inappropriately allocated and might intimidate or bully others.
9. The prison's Independent Monitoring Board (IMB) annual report of 2007 also identified healthcare staffing levels as a concern. They noted that a "persistent reliance on agency staff undermines the teamwork and continuity ethic". The IMB's annual report of 2008 noted that there were problems regarding access for the disabled on Houseblock 4.
10. The man's death was the tenth death to have occurred at Elmley since April 2004, when I began investigating all deaths in prison custody in England and Wales. It was the sixth due to natural causes.
11. One of the previous investigations that I carried out at Elmley also involved the death of an older prisoner who had a number of significant health problems. I concluded that the treatment and prescribed medication was appropriate in his case, and that the care the man received was equivalent to that which he would have expected to receive in the community.

## KEY FINDINGS

12. At the time of his conviction, the man had an extensive medical history. In 1993, he was found to have end stage renal (kidney) failure. He was treated with dialysis for around two years before having a transplant. The transplant was successful and, at the time of his imprisonment, he had normal kidney function. However, as a result of the transplant, he was required to take a number of different medications including prednisolone (to help control conditions such as asthma and rheumatoid arthritis, both of which he had developed), cyclosporine (to prevent the rejection of the transplanted organ), and frusemide (to encourage the kidneys to get rid of unneeded water in urine and hence reduce swelling and water retention in the body). He also had high blood pressure, for which he took doxazosin.
13. The man was also dependent on crutches to walk as a result of a left-hip replacement in 1999. Asthma (for which he took a salbutamol inhaler) had been diagnosed in 2001 and a recent scan had shown the presence of chronic obstructive airways disease (COAD, a disease of the lungs in which the airways become narrowed, now referred to as chronic obstructive pulmonary disease or COPD). He had also developed glaucoma (damage to the optic nerve behind the eye) in 2001 and used eye drops, although his sight was said to be unimpaired in a medical report prepared for his solicitor.
14. Following his arrival at Elmley on 22 July 2005, the man was seen by a nurse for a first reception health screen (a routine health screen for all new arrivals into prison). His medical history, including his kidney transplant, COAD, glaucoma and reduced mobility, was noted. On account of his extensive medical history, he was initially located on the inpatient wing for assessment.
15. A disability questionnaire was completed with the man on the same day. He was noted as having reduced mobility and reduced physical capacity. His use of crutches was also recorded. The assessor wrote that the man should be located on the flat (the ground floor) and in a lower bunk.
16. After four days on the inpatient wing, the man was assessed as fit to live on a prison wing. He moved to a ground floor cell on Houseblock 4, the vulnerable prisoners unit (VPU, for prisoners who request to be separated from the majority of prisoners because of factors such as the type of offence committed). He was seen in his cell by a nurse on 31 July after becoming very short of breath. He was given salbutamol via a nebuliser (a device similar to an inhaler) and was noted to be much better afterwards.
17. On 7 September, the man attended a routine transplant clinic at an outside hospital. His kidney was noted to be doing well, although the consultant observed that his blood pressure had gone above normal levels. The man said that he had missed a week of doxazosin and so the consultant prescribed a further course. He also noted that the man had conjunctivitis and booked an appointment for him to see the ophthalmic department (eye specialists).

18. At his next renal clinic, on 9 November, the consultant wrote that the man's conjunctivitis was now better. However, he was noted to have swollen ankles. The consultant diagnosed oedema (fluid retention) and increased his dose of frusemide.
19. Five days later, the man returned to the outside hospital to be seen by the eye specialist. He was diagnosed with an eye infection and prescribed antibiotics.
20. On 21 December, the man asked to see a nurse who noted that he had very swollen and discoloured feet and ankles. The nurse advised that he see a prison doctor that afternoon, which he did. The doctor subsequently increased his dose of frusemide for 28 days.
21. During a routine cell search on 11 January 2006, officers found around two months worth of medication in the man's cell. All of the medication was taken away, except that which was needed in the next few hours. It was agreed that he should use blister packs so that it was easier for him to take his medication at the correct time.
22. A nurse was called out to the man 16 March, when he experienced an exacerbation of his asthma. The nurse noted that he was experiencing some shortness of breath, but was able to speak in full sentences. He was given oxygen, and after 15 minutes his condition had improved. He declined the offer of admission to the healthcare centre.
23. On 26 April, the man attended a routine transplant clinic at the outside hospital. He told the consultant that he was struggling to climb the two flights of stairs on his houseblock and that he felt dizzy and light headed at the top of the stairs. The consultant wrote to the prison questioning whether anything could be done to improve this situation. There is no record of any reply to the consultant or of any action being taken.
24. The man spoke to a nurse on 9 May 2006 and complained that he was not receiving his medication in full. He spoke specifically of frusemide, and said that he should be taking 80mg per day. The nurse checked his prescription chart, and found that his medication had been issued correctly and in full. He advised the man of this, and emphasised that his prescription was for 40mg of frusemide each day.
25. Ten days later, the man reported that he had fallen and hit his head on his cell wall. He was seen by a nurse and noted to have small cuts to his right hand and the top of his head. The nurse assessed that no treatment was required. He was seen by a different nurse on 24 May. He spoke of his fall five days previously and said that his left knee had given way and that it might have been a temporary loss of consciousness. He said that he still felt dizzy and the nurse noted that his feet were still swollen. The nurse recommended that he see a doctor that afternoon. After assessment, the doctor increased the man's dose of frusemide to 80mg per day on account of his swollen feet.

26. At his next transplant clinic on 28 July, the man told the consultant that his medication, including the anti-rejection drug cyclosporine, was frequently withheld. The consultant wrote a strong letter to the medical officer (prison doctor) at Elmley saying that it would be “highly irresponsible” if the man did not get his cyclosporine. A hand written note following the letter, and dated 2 August, says that the matter had been investigated and the man was getting regular medication in blister pack form. It was noted, however, that “his compliance has a lot to be desired”.
27. On 7 August, the man complained to a nurse that he had not had his seretide inhaler (used to reduce inflammation of the lungs and keep the airways open) for a week. The nurse noted that prescription records showed that he had recently received his inhalers. A week later, a response nurse was called out to his cell in the evening as he was reported to be having an asthma attack. On arrival, the nurse found that he was hyperventilating rather than having an attack. The nurse encouraged him to breathe steadily and noted that a nebuliser was used to good effect.
28. The following day (15 August 2006), the man was admitted as an inpatient to the healthcare centre when he was found to have extensive red lesion around his left hip. He was diagnosed with shingles. He remained as an inpatient for three days and took a course of aciclovir (an antiviral drug) and paracetamol (pain relief).
29. The man attended an eye clinic at the outside hospital on 22 August. In a letter following the clinic, the optometrist wrote that the man had complained that some of his eye drops had been removed from his cell. A note in his medical record on 6 September indicated that he was having difficulty with medication storage in his cell. He was advised not to have more medication than he needed.
30. An entry in the man's medical record on 2 December notes that his sister had telephoned the prison to say that he was not receiving all of his medication. The entry, which is unsigned, goes on to say that all of the prescribed medication had been issued.
31. On 3 January 2007, the man reported to a nurse when collecting his medication that both of his ankles were swollen. The nurse noted that there was no frusemide (the medication he took to reduce swelling and water retention) in his blister pack. The nurse observed that his most recent prescription was to take 40mg and 80mg on alternative days, and noted that the medication should be followed up. Examination of his prescription chart indicates that he was given frusemide on the same day.
32. A week later, the man again said that he did not have the correct medication. His cell was searched and a large quantity was found, some dating from several months previously. It was decided to trial him for a month on a daily collection of medication, whereby his empty packets had to be returned before he would receive a new supply.

33. A referral to the prison's mental health in-reach service was made by a nurse on 15 January. The nurse thought that the man was experiencing increasing short term memory loss, as he kept repeating the same questions about his medication. He was assessed by a member of the in-reach team two days later. The assessment found no evidence of mental health problems and concluded that no further input was required.
34. The following week, the man again complained that mistakes were being made in administering his medication. He did not mention which particular drugs were concerned. He requested a return to weekly in possession medication. It does not appear that this request was agreed to.
35. On 6 February, the clinical nurse manager at Elmley wrote to the consultant in response to a letter that he had written regarding the man. (It is not clear if this was a response to the letter of 28 July 2006 or later correspondence.) She made the following comments about the man's prescription:

“[The man] is issued his medication weekly on a Wednesday in blister packs as he is getting confused as to what to take and when. He is a difficult man who struggles to conform to procedures to collect his medication at the correct time, or to renew his prescriptions. Our nurses, however, are aware of the importance of his medication [and] therefore do all in their power to ensure he complies with his prescribed medication.”
36. The clinical nurse manager's comments that the man was receiving weekly in possession medication contradict the evidence of his prescription chart and the agreement of 10 January. Both of these sources show that he was receiving his medication on a daily basis at the time.
37. The following day (7 February 2007), the man attended hospital for his regular transplant clinic. Following the appointment, the consultant wrote to Elmley to pass on complaints that the man made regarding his prescription of co-codamol (pain relief) at the prison. He had told the consultant that his co-codamol prescription had previously been eight tablets per day, but that this had been reduced as he did not always need to take all eight in a day. However, he said that occasionally he did require eight tablets per day and when he did they were not available.
38. It does not appear as though a formal reply was sent to the consultant with regard to this matter. However, examination of the man's prescription chart for this time confirms that he was receiving one tablet to be taken four times daily. This had been the case since the previous August, when his prescription was for one to two tablets four times daily as required. It is not clear from the notes why the dosage was reduced.
39. The prescription chart shows that the man's co-codamol was increased to two tablets four times a day from 8 March. There is again no note in his medical record to indicate why the change was made.

40. On 14 March, the man submitted an application to have his medication in possession rather than a daily delivery. The reply, dated two days later, says that the man was called to discuss this with the clinical nurse manager but did not attend. Two weeks later he was reviewed by a prison doctor. Following a three way discussion, involving the prison doctor, the clinical nurse manager and the man, it was agreed that he would have weekly in possession medication, with a weekly visit by a nurse to ensure he was receiving and taking his medication as required.
41. The man was taken to the healthcare centre by wheelchair on 3 May after falling off his bed onto the floor. He was noted to have some bruising and a small graze. He was able to move fully and returned to his houseblock on the same day. A precautionary x-ray of his left hip (the one that had been replaced) was taken on 15 May. This showed nothing unusual resulting from the fall. At a routine clinic at another outside hospital on 23 May, it was noted that he was moving well and that his left hip was satisfactory.
42. At 6.00am on 30 June, the man called the night patrol to his cell and said that he had fallen out of bed. A code red (an emergency call for urgent medical assistance) was raised, and a nurse attended. He was treated for a small cut to his forehead. Later that morning, he declined to take his medication as he said he was feeling sick.
43. The clinical nurse manager wrote to the man's solicitor on 16 July regarding his medical treatment. It would appear that the solicitor had written to Elmley raising concerns about the treatment that he was receiving, although a copy of this letter was not on the file. The clinical nurse manager's reply consisted of the following:
- “[The man] has his nebuliser in his possession and is supplied with the correct medication to use in it. If he has a problem using his nebuliser there is a nurse in the prison 24 hours a day to assist him ... [The man] has previously not taken his medication as prescribed in fact he has found to have months worth of medication in his possession whilst claiming we have failed to provide it. We have tried various means to try and assist [him] to take his [medication] as prescribed ... The doctor has assessed [him] as fit to attend the treatment hatch, stating that this short journey will help to keep him mobile. If [the man's] condition deteriorates we will certainly deliver his medication to him.”
44. The following day, the man attended a routine appointment at the eye clinic at the outside hospital. The consultant noted that his vision had improved and his eyes were generally comfortable. He stressed, however, that it was important that the man remained on his current medication and that fresh supplies should be made available as soon as he ran out.
45. Through the autumn of 2007, the man had fewer consultations with healthcare staff than previously. He was seen by a nurse on 1 October after experiencing shortness of breath, and was seemingly better after taking his nebuliser. Ten days later, he reported increased swelling in his

- ankles. When seen by a nurse, he said that the swelling was now going down. He was advised to elevate his legs when possible.
46. A panel from the Parole Board met on 22 January 2008 to consider the man's application for early release. They found that he was not suitable for release because he had not completed the sex offender treatment programme (SOTP, a course aimed at addressing the reasons for a prisoner's offending behaviour) whilst in prison. He had been assessed as unsuitable for SOTP due to his denial of the offences for which he had been convicted (although his sister later told my senior family liaison officer that her brother did not wish to take the course because he was opposed to some of its content). The panel noted, however, that he had begun to accept responsibility and that a place had been found for him on a forthcoming course.
  47. The man attended a regular transplant clinic on 5 March. The consultant noted that the fluid retention around his ankles was very obvious, and increased his dose of frusemide. A week later, the man saw a prison nurse and said that his asthma was getting worse, especially at night.
  48. A violence reduction investigation report was completed on 23 March because the man had made several allegations against a fellow prisoner in February. He said that the prisoner was making offensive remarks towards him. The report said that the incident had been dealt with by a principal officer (PO), the manager of Houseblock 4. The PO had moved the other prisoner to a different spur (a corridor of cells) away from the man.
  49. A second violence reduction investigation report was submitted the following day. The man had told a senior officer on the houseblock that, from 2 to 7 March 2008, a prisoner had been threatening and abusing him and had thrown a plate at his face. The investigation report said that the alleged perpetrator had since been released from custody.
  50. Another violence reduction report was submitted towards the end of April (the exact date is unclear). The man had complained that a prisoner had been threatening him and pushing him off the telephone. This report again said that the alleged perpetrator had subsequently been released from custody.
  51. On 20 April, the man submitted a complaint form. He said that a visit on 2 April had been delayed by an hour because the wheelchair had been removed from the houseblock. The response was written by the PO on 23 April. The PO said that the chair had been returned to the houseblock and could be used.
  52. The same day, the man submitted a second complaint form. He said that the wheelchair to which the PO referred actually belonged to another prisoner. The PO replied to the second complaint on 2 May. He said that he had checked and there was a wheelchair on the houseblock that the man could use.

53. The man was seen by a nurse with regard to his asthma on 1 May. She noted that his peak flow technique (how hard and fast air is blown from the lungs) was very poor, and referred him to the doctor and specialist respiratory nurse. The following day, he reported that he had accidentally cut his left leg. When he was examined by a nurse, she noted that the wound had stopped bleeding but was exuding water. He was seen later that day by the doctor for review on both concerns.
54. When the man was seen by another prison doctor, he said that he had been feeling unwell for two days. The second prison doctor noted that the man had increased ankle swelling and difficulty breathing. He commented that there was an appearance of an atrial flutter (abnormal heart rhythm) and left ventricular failure (failure of the left side of the heart to pump blood properly). In the light of these findings, and combined with his medical history, the second prison doctor arranged for him to be admitted to a third outside hospital for further examination.
55. The man was discharged from hospital six days later. Whilst in hospital he had undergone an ECG (a procedure that produces an image of the heart) which confirmed the diagnosis of abnormal heart rhythm. As a result, he was prescribed warfarin (a medication that thins the blood and reduces the risk of a stroke) and diltiazem (medication for high blood pressure).
56. Two weeks later, on 22 May 2008, the man was reviewed by the first prison doctor. He observed that the man was reluctant to take diltiazem (the reason is not recorded) and was confused how and why he had been prescribed warfarin. The prison doctor noted that no formal discharge letter had been received from the hospital.
57. On 12 June, the man was admitted to the healthcare centre as an inpatient. The reason given on his admission sheet was for "physical observations". No further details are provided, although a week earlier a decision had been made to allow him to attend healthcare twice weekly for a bath due to the level of assistance that he now required. He lived on the inpatient wing for the remainder of his life.
58. On account of his frail condition, it was arranged for the man to have his meals and medication delivered to his cell. His level of mobility was now poor and it was noted by a third prison doctor that he needed a wheelchair to get around where possible.
59. Two days after his admission, the man was reviewed by the first prison doctor. He noted that the man looked well but should not be forced to mobilise due to his irregular heartbeat. On the same day, it was noted by a nurse that he was able to use a Zimmer frame to cover short distances around the inpatients unit.
60. A care plan, consisting of actions for dealing with a number of the man's needs, was produced on 19 June. Among the problems addressed was his mobility. The care plan instructed that he should be encouraged to use his crutches to move around his cell and along the corridors of the

inpatient wing, with the supervision of a member of staff. For longer distances, including the chapel and visits hall, a wheelchair was to be used.

61. The care plan also included instructions for the administration of the man's medication. It was noted that he became anxious if his medication was not administered at the same time every day. Instructions were therefore given to prescribe his medication at set times and provide clear explanations to any questions that he asked.
62. In late June, the man experienced some pain and swelling in his right elbow. He was prescribed a course of antibiotics. It was also noted on 28 June that he had received a wheelchair that had been sent in for him.
63. By 2 July, the pain and swelling in the man's elbow had reduced considerably. He was reasonably settled over the next few days and was noted to be eating and drinking well, looking after his personal hygiene, and taking his medication as prescribed. However, on 8 July 2008, he said that he was not feeling well and that he had no appetite and had not been eating. A course of Fortisips (a nutritional supplement) was started and instructions were given for him to be weighed twice weekly. He also complained that the pain and swelling in his elbow had flared up again. He was therefore prescribed a further course of antibiotics.
64. The following day, the man attended the outside hospital for a routine transplant clinic. The hospital consultant recommended that the man stop taking doxazosin (medication for high blood pressure that he had been taking for a number of years) as his blood pressure was low at 100/80. This information was given to the escorting officers and his dose was stopped the following day.
65. The hospital consultant asked for a blood test to be taken on 9 July, to include a digoxin level. (Digoxin is a medication used to increase the strength of heart contractions and is used as a treatment for atrial flutter.) It is not clear from the notes when this medication was first prescribed for him. The first recorded prescription was dated 28 May 2008, although some prescription charts covering earlier weeks in the month are missing. From 29 May, however, the man took digoxin 0.25mg on a daily basis as a 'not in possession' medication (meaning that the medication would be given to him daily by nursing staff). On 14 June, a new prescription was written with the instruction that the daily dose be omitted if his pulse were to fall below 60 beats per minute.
66. The results of the man's blood test were included in the hospital consultants discharge letter. This was written on 14 July, two days after the man died. The letter was not received at Elmley until 11 September, when a prison doctor contacted the hospital to request a copy. The hospital consultant included the results of the blood test in a postscript to the letter, with the following advice:

"Please note a very high digoxin level. I suspect he is toxic. Please repeat a six-hours post dose sample urgently."

67. Two days after returning from his consultation (11 July), the man scalded his right ankle after a kettle fell on him. Cooling gel and a dressing was applied. He spent the remainder of the day lying on his bed after saying that he was very tired.
68. On the same day, the man's care plan was updated. Staff were now instructed to record everything that he ate and drank on a chart that would be kept in his cell. He was still encouraged to move around the inpatients wing on his crutches with the supervision of a member of staff.
69. The following morning (12 July), the man was able to eat a little breakfast. However, he was noted to be lethargic and unwilling to engage in conversation. He took his morning medication after prompting, although declined his noon medication and said that he was not feeling well. The nurse told him that she would ask the first prison doctor to see him that afternoon.
70. At around 4.40pm, the doctor went to see the man, with a prison nurse. He was sitting in his wheelchair. The first prison doctor examined him and found that his breathing was poor and there was no heart sound or pulse. The prison nurse requested an emergency ambulance at 4.42pm, whilst the first prison doctor used a defibrillator to check the man's heart. The doctor and nurse followed the instructions given by the defibrillator and began cardiopulmonary resuscitation (CPR). This continued following the arrival of the paramedics at around 5.08pm. Their efforts were unsuccessful and the man was pronounced dead by the first prison doctor at 5.17pm. The cause of death was later given as ischaemic heart disease with a secondary condition of chronic obstructive pulmonary disease.
71. The man's next of kin was listed as his son, who lived about 80 miles from Elmley. The duty governor decided that, alongside a chaplain, he would personally break the news to the man's son. However, they were not given permission by the police to visit until 9.00pm that evening (the police are required to investigate all deaths in prison custody to ensure that there are no suspicious circumstances). The duty governor and chaplain decided that it was too late to visit that evening. In addition, the duty governor had been on duty since early that morning, when he had been informed of an earlier death in custody. He did not think that he was fit to drive the distance to visit the man's son after a long and tiring day. The duty governor and chaplain therefore went to break the news the following morning, arriving at around 11.00am. Unfortunately, they found that his son was not at home.
72. At around 1.00pm, the man's sister and her husband arrived at Elmley for a visit. They were met at the gate by a PO and another chaplain who broke the news of the death to them. A memorial service was held in the prison chapel later that afternoon which the man's sister and her husband attended. They were also shown the room on the inpatients wing where he had lived.

73. The man's funeral was held on 29 July 2008 and was attended by the chaplain on behalf of the prison. My investigator found that the prison's contribution to the funeral arrangements was in accordance with PSO 2710 (the Prison Service Order that sets out the actions to be taken following a death in custody).

## ISSUES

### Medication and continuity of care

74. The man's sister told my senior family liaison officer that her brother had problems getting the correct medication whilst in prison. She said that he was sometimes given the wrong medication, and was laughed at when he complained about this. His sister specifically mentioned his painkillers and said that they were sometimes changed to the detriment of her brother's pain relief.
75. The man spoke to healthcare staff on numerous occasions about the provision of his medication. He also complained to his solicitor and a consultant in renal medicine at the outside hospital, both of whom wrote to the prison with these concerns.
76. It is clear from his medical record that the man struggled to comply with his medication regime. He was regularly confused about what medication to take and when to take it. Around six months after his arrival at Elmley, a substantial quantity of medication was found in his cell, all of which he had failed to take at the correct time. He was therefore given his medication in blister packs on a weekly basis, so that it would be easier for him to identify the proper time to take it.
77. The clinical nurse manager at Elmley told my investigator that the introduction of blister packs did improve the man's compliance to some degree. However, it was still clear that he was having difficulty taking the correct medication at the correct time. In January 2007, when he was again found with a large stockpile of medication in his cell, it was agreed to initiate a trial whereby he would receive his medication on a daily basis. As part of the trial, his empty packets would have to be returned before he received fresh supplies.
78. The trial was initially due to last for one month, although it was extended to two. However, the clinical nurse manager said that the man was "incredibly resistant" to it and felt that having to collect his medication daily was a punishment. The trial was stopped and he returned to taking his medication weekly in blister pack form. It was decided that he would have a weekly visit from healthcare staff to ensure that he was taking his medication as required. It is not clear from the medical record whether this actually happened.
79. The head of professional development in healthcare at Elmley told my investigator that the introduction of a nurse based on Houseblock 4 helped with the man's medication compliance. The nurse was based on the wing from February 2008 and distributed medication to him in his cell every week.
80. The man's sister spoke of his difficulty in getting the correct painkillers. This was an issue that he himself raised at a consultation at his transplant clinic on 7 February 2007. The man told the consultant that his prescription of co-codamol had been reduced from eight tablets per day

because he did not always need to take them all. However, he said that there were occasions when he did require all eight tablets.

81. Examination of the man's prescription chart shows that he was taking one tablet four times daily at the time of this consultation. This had been the case since August 2006 when his prescription had been changed from one to two tablets four times a day, as required. On 8 March 2007, entries in his prescription chart show that his co-codamol dose was increased to two tablets four times a day.
82. In neither August 2006 nor March 2007 was any entry made in the medical record to indicate why his prescription was changed. This is also the case on other occasions, including the prescription of digoxin in May 2008.

**The head of healthcare should remind prison doctors to record the reasons for any changes to a patient's medication in the patient's medical record.**

83. The clinical reviewer considered the dispensing of medication to the man at Elmley. He came to the following conclusions:

"I can find no evidence that there was anything other than a conscientious attempt by all staff to ensure that [the man] received his correct medication at the correct times.

"His drug regime was multiple and complex requiring adjustment according to changes in his mental state. The compromise between dosage and the prevention of the accumulation of unused drugs which have an in-prison currency value is one which is of immense importance to healthcare staff.

"Nothing I find in my review of medical records points to any deliberate attempt to deny [the man] his correct medication ... [The man] was an intelligent and educated man. Doubtless he would have been quite assertive in his demands for appropriate and necessary treatment. On review of available medical and prescription records, I have no doubt this is what he received."

84. It is clear to me that the man was, at times, a challenging patient for healthcare staff at Elmley. I have found no evidence that he was disrespected at any time by staff at Elmley when requesting changes to his medication. I agree with the clinical reviewer's conclusion that their efforts to help him take the correct medication were conscientious and appropriate. However, as the clinical reviewer also notes, the man was an intelligent and educated man. It is therefore somewhat surprising that he should have had such difficulty complying with his prescriptions. Other than a referral to the prison's mental health in-reach service in January 2007 (which found no evidence of any mental health problems), it does not appear that much thought was given to determining the reasons for his non-compliance.

85. The man's sister told my senior family liaison officer that she had spoken to the head of professional development in healthcare about her brother having a named nurse to help him take his medication. She went on to say that this rarely happened because of staffing levels.
86. The head of professional development in healthcare and the clinical nurse manager told my investigator that the introduction of a nurse based on Houseblock 4 worked in a similar way to a named nurse. It resulted in a core of staff getting to know the needs of the patients on the houseblock, and therefore providing better continuity of care.
87. The clinical reviewer addressed the issue of a named nurse in his report:
- “A named nurse would doubtless have been beneficial, but not really practical. The dispensing and supervision of medication by a designated nurse is a luxury that does not exist in hospital or community practice, far less in custody. It is impractical because medication is prescribed to be taken from morning to night, seven days a week, and no designated person could be available for these lengths of time. The prescribing sheet allows various nurses to follow the prescribed regime. If a variation on this is necessary then it would require a doctor's consent and signature. In possession medication can obviously however be at the patient's discretion and [the man's] needs fluctuated.”
88. I agree with the clinical reviewer that having a single nurse to help the man on the houseblock would have been impractical. However, the benefit of having a core of nursing staff who are familiar with the specific needs of patients with multiple health problems is undeniable. In the light of this, I welcome the initiative to station a nurse on Houseblock 4.

### **Time taken to see the man when he fell and injured his head**

89. The man's sister said that on one occasion her brother fell and hit his head. She said that he was taken to his cell at 2.00pm but was then not seen by anyone until 5.00pm. She did not provide a date on which this incident occurred.
90. Examination of the man's prison records show three occasions on which he fell over. The first was on 19 May 2006 when he was reported to have fallen and hit his head on his cell wall. The incident is reported to have occurred at 12.25pm. It is not recorded when he was seen by a nurse. However, it is noted that his injuries were a “small cut to right hand and top of head”. The nurse noted that there was “no treatment required” and “no need to see [prison doctor]”. The time that he saw the nurse should have been recorded.
91. The second fall occurred on 3 May 2007 at around 6.15pm. On this occasion it was reported that the man had fallen off his bed and onto the floor. He was seen by a nurse at 6.50pm. The nurse noted that the man had bruised his left hip and had a small graze to his left hand. A

precautionary x-ray on 15 May showed nothing unusual resulting from the fall.

92. On 30 June 2007, the man called the night patrol to his cell at around 6.00am and said that he had fallen out of bed. A code red (an emergency call for urgent medical assistance) was called and a nurse attended. He was treated for a small cut to his forehead.
93. It is not clear whether any of these incidents is the one to which the man's sister was referring. However, there are no other recorded falls in her brother's prison records. On each of these three occasions he was treated for minor injuries. I am satisfied that he was dealt with appropriately.

### **Mobility**

94. The man's mobility was poor when he arrived at Elmley. Following a hip replacement some years earlier, he required crutches to walk. As a result, he was allocated a cell on the ground floor of his houseblock.
95. Despite being on the ground floor of Houseblock 4, the man still had some stairs to negotiate. To get to the exercise yard he had to go down one step. To get to the servery for meals he had to go down three steps. He was generally able to negotiate these steps. In addition, he was allocated a fellow prisoner to help him with tasks such as collecting his meals and cleaning his cell.
96. More significantly, the treatment hatch where the man had to go to collect his medication was on the second floor of the houseblock. This meant that he had to climb two flights of stairs to collect his medication. His sister told my senior family liaison officer that this was very hard for him and that on one occasion he had to crawl upstairs.
97. The man spoke to a consultant at the outside hospital on 26 April 2006 about the stairs on his houseblock. The consultant wrote to Elmley and said that the man was "struggling to climb the two flights of stairs ... I wonder if anything can be done to improve the situation for him." There is no record of a reply to the consultant or of any assessment or action being taken.
98. On 16 July 2007, the clinical nurse manager wrote to the man's solicitor following receipt of a letter regarding his medical treatment. In her letter, the clinical nurse manager made the following comments relating to the collection of the man's medication:

"The doctor has assessed [the man] as fit to attend the treatment hatch, stating that this short journey will help to keep him mobile. If [his] condition deteriorates we will certainly deliver his medication to him."
99. There is no record in his medical notes of this doctor's assessment being carried out. However, a change to the man's regime apparently took

place in February 2008. The head of professional development in healthcare told my investigator that the nurse who was based on Houseblock 4 from that time distributed the man's medication to him at his cell every week.

100. Whilst he was able to walk on crutches around short distances on his houseblock, the man required a wheelchair to move over longer distances around the prison. His sister told my senior family liaison officer that he was often late for visits because of the time it took for him to get to the visits hall.
101. The disability liaison officer at Elmley told my investigator that he received a complaint from the man in February 2007. He said that his visits were being cut short because he could not get to the visits hall on time. On account of his limited mobility, he had to be taken on a flat route to the visits hall in a wheelchair. As a result, he was not able to move at the normal movement times. The disability liaison officer discussed this with a principal officer on Houseblock 4 and agreed a system whereby anyone who had to be taken to visits in a wheelchair could go at the normal time. The disability liaison officer said that, other than some teething trouble in the first month, the system seemed to work and he did not hear from the man again.
102. The man's sister told my senior family liaison officer that she twice tried to have a wheelchair sent in for him, but was told that one was available already. She said that she tried to have a wheelchair sent in because her brother was often late for visits. The principal officer (PO) confirmed that he had spoken to the man's sister in May or June 2008 on the subject of wheelchair access. He told my investigator that the problem was not one of access to a wheelchair, but of the route that he was being taken to get to the visits hall. The PO said that the route was not particularly easy to negotiate and that he arranged for staff to take him on a flatter route. He said that this appeared to resolve the difficulty.
103. The PO went on to say, however, that there had been a period when the wheelchairs on the houseblock were withdrawn for servicing. This led to some difficulty taking the man to the visits hall. These events would appear to be those referred to by the man in a complaint form that he submitted on 20 April 2008 in which he spoke of a wheelchair being removed on 2 April. The complaint form was responded to by the PO who advised that a wheelchair had now been returned to the houseblock. The man replied on 23 April to say that the wheelchair belonged to another prisoner and was not for general use. The matter appears to have been resolved on 2 May when the PO confirmed that there was a wheelchair on the houseblock that the man could use. These events clearly caused some distress for him, and it is very regrettable that his visits were delayed.

**The disability liaison officer should consider alternative arrangements for transporting prisoners with limited mobility around the prison should the wheelchairs on a houseblock be unavailable.**

104. Following his admission to the healthcare centre as an inpatient in June 2008, the man's mobility deteriorated further. There appears to have been some contradiction in the advice given about his mobility. On 12 June 2008, for instance, the third prison doctor noted that he "needs a wheelchair to get around where possible". Two days later, however, the man was noted to be using a Zimmer frame to cover short distances around the inpatients wing. In a care plan produced on 19 June, it was agreed that he should be encouraged to use his crutches to walk around the corridors of the inpatients wing but that a wheelchair should be used for longer distances.
105. The clinical reviewer made the following comments about the man's mobility in his report:
- "[The man] used walking aids throughout his time in custody. Availability of a wheelchair is mentioned in the medical record and on 13 June 2007 it was noted that he 'needs mobility accessible vehicle'. The physical environment in prison must make the use of mobility aids more problematic, but again I find no evidence that [the man's] needs regarding mobility went unheeded and unmet. I cannot find any formal mobility assessment, but given his physical problems and the fact that he was in custody he was unlikely ever to want or need to move around very much whatever assistance was given."
106. Whilst the clinical nurse manager's letter of 16 July 2007 mentioned that the man had been assessed as fit to attend the treatment hatch, there is no evidence of a formal mobility assessment being carried out at any time. There appears to be a discrepancy between what the man and his family thought he was capable of and what was expected of him by prison staff, particularly with regard to collecting his medication. There is little evidence in his notes of this being discussed with him.

**The head of healthcare should ensure that a mobility assessment, to address issues including the collection of medication, is carried out for all prisoners who are noted to have mobility problems.**

## **Bullying**

107. The man's sister told my senior family liaison officer that her brother was bullied in prison. She said that this was on account of his age, frailty, intelligence and offence. She went on to say that her brother had ping pong balls thrown at him whilst he was on the telephone, and that he was poked by billiard cues.
108. Three violence reduction investigations were carried out following complaints made by the man about his treatment at the hands of other prisoners (see paragraphs 50-52 for details). Each complaint referred to other prisoners threatening him. On one occasion, the alleged perpetrator was moved to a different spur on the houseblock. On the other two occasions, the alleged perpetrator had been released from custody soon after the allegations were made.

109. The PO, the manager of Houseblock 4, told my investigator that the man was “seen as an easy target” by some prisoners. He said that he received some verbal abuse, and there was one occasion on which other prisoners threw orange peel at him when he fell over. The PO said that staff tried to keep more of an eye on him following these incidents. They also moved him to a different spur, where he was near to quieter and more reliable prisoners.
110. The man’s personal officer (each prisoner is assigned an officer who they can go to first with any problems) told my investigator that the man raised some issues of bullying with him, which he dealt with straight away. He said that he moved the prisoners who were bothering him to different cells. He said that he also arranged for him to move cells on three occasions to make life more comfortable for him.
111. The personal officer said that the man was bullied because he was an older prisoner and therefore an easier target. He added that some prisoners were trying to steal his co-codamol. To resolve this, the personal officer said that he arranged for some of his medication to be locked in the wing office for a period to prevent him having too much in his cell. He said that this resolved a lot of the pressure on the man.
112. The PO and the personal officer spoke of several incidents of bullying in which the man was the victim. My investigator was provided with evidence of only three occasions in which details were passed to the violence reduction co-ordinator to investigate.

**The Governor should remind staff that all instances of bullying should be reported to the violence reduction co-ordinator for investigation.**

113. The incidents described above by the PO and personal officer were each dealt with as they occurred. Given his obvious vulnerability, staff might have taken a more proactive approach and sought solutions that would provide longer term protection for the man.

**A system should be established whereby the wing staff alert the violence reduction co-ordinator of those prisoners who might be vulnerable to bullying so that measures can be implemented to ensure their safety.**

114. At his interview with my investigator, the PO said that the man was “seen as an easy target by those prisoners who were perhaps on the houseblock for the wrong reasons”. This is a theme that was picked up on by Her Majesty’s Chief Inspector of Prisons. During her most recent inspection of Elmley in December 2006, she found that Houseblock 4 held a number of prisoners who were inappropriately allocated and might intimidate or bully others. She made the following recommendation:

“The prison should reduce the number of spaces for vulnerable prisoners so that provision more accurately reflects the needs of the population.”

115. Elmley gave the following response to this recommendation:

“All prisoners located on Houseblock 4 are there by their own request, subject to assessment and suitability. No prisoners are placed there in order to reduce population pressures elsewhere within the establishment.”

116. From March 2009, all prisoners on Houseblock 4 at Elmley who have been convicted of sexual offences are to be moved to HMP Maidstone. Those vulnerable prisoners on the houseblock who have been convicted of other offences will move to Houseblock 1.

### **Was the man eating properly towards the end of his life?**

117. One of the aims of the care plan created on 19 June 2008 was for the man to maintain a healthy diet. Healthcare staff were instructed to encourage him to choose a healthy diet from the menu, and to take his meals to his cell for him.

118. Entries in his medical record in early July indicate that the man was eating and drinking well at the time. However, on 8 July, he said that he had no appetite and had not been eating. He was prescribed a course of Fortisips (a nutritional supplement) and instructions were given that he should be weighed twice weekly.

119. On 11 July, the man’s care plan was updated. It was now recorded that he should be encouraged to eat and drink and that everything that he consumed should be recorded on a food and fluid chart.

120. The clinical reviewer gave the following opinion about the man’s food and fluid intake:

“There is documented evidence of end of life weight loss and concern over [the man’s] level of nutrition. This was included in his care plan where it is noted he was ‘encouraged’ to eat. Weight loss with inactivity, COPD and ischaemic heart disease can be regarded as normal since they would all lead to reduced appetite. I find nothing to suggest that [he] was not helped and encouraged to eat as well as he felt able.”

### **Prescription of digoxin**

121. As noted earlier, digoxin is a medication used to increase the strength of heart contractions. It is used as a treatment for atrial flutter (abnormal heart rhythm), with which the man had been diagnosed during an inpatient stay at the outside hospital between 2 and 8 May 2008. It is not clear when he began to take this medication. During a consultation with a prison doctor on 22 May, it was noted that no discharge letter had yet been received from the hospital. Digoxin was recorded in his prescription chart from 28 May onwards, although the charts for earlier in the month are missing.

122. At a routine transplant clinic on 9 July, the consultant asked for a blood test, including digoxin levels, to be taken. The results of the blood test were included in a discharge letter of 14 July, two days after the man died. This letter was never received at Elmley. Its contents only came to light when the first prison doctor contacted the hospital on 11 September with regard to a report he was preparing for HM Coroner.

123. The consultant included in his letter the following comment about the results of the man's blood test:

“Please note a very high digoxin level. I suspect he is toxic. Please repeat a six-hours post dose sample urgently.”

124. The clinical reviewer noted in his report that the toxicology report (an analysis of blood samples taken after death) did not test the man's blood levels for digoxin. He went on to say that “it therefore remains within the bounds of possibility that digoxin toxicity was a factor in his death.”

125. I make the following recommendations, based on those made by the clinical reviewer in his report:

**The healthcare manager should ensure that procedures are in place to follow up any hospital discharge letters that are not received in a reasonable time.**

**The healthcare manager should consider the routine measuring of patient blood drug levels where toxicity or non-compliance could exacerbate current medical problems.**

### **Breaking the news of the man's death to his next of kin**

126. The man's next of kin was listed as his son, who lives around 80 miles from Elmley. The duty governor and chaplain were due to break the news of the death to the man's son. However, they were not given permission by the police to do so until they had finished their enquiries at the prison at around 9.00pm. The duty governor and chaplain decided that it was now too late to visit the family. In addition, the duty governor had been on duty since early that morning, when he had been informed of an earlier death in custody. He did not think that he was fit to drive the distance to visit the man's son after a long and tiring day.

127. The following morning, the duty governor and chaplain visited the man's son. They arrived at around 11.00am, but found that he was not at home. They were therefore unable to break the news of his father's death. Around two hours later, the man's sister and her husband arrived at Elmley on a visit. They were met by a second PO and another prison chaplain, and it was they who broke the news of his passing.

128. Prison Service Order (PSO) 2710, which offers guidance and instructions for actions to be taken following a death in custody, says that Governors must:

“Arrange notification to the next-of-kin and any other person reasonably nominated by the prisoner as soon as possible in a suitable manner, giving an accurate factual account of what has happened.”

The PSO makes no reference to the time of night being a factor in determining when and how to inform the next of kin of a death in custody.

129. The accompanying family liaison officer guidance recommends that:

“The family should be informed face to face as soon as possible after the death. Wherever possible this should be done by a dedicated family liaison officer working alongside the chaplain, or governor or most senior individual available together with the chaplain ... If distance from the prison presents a problem, a dedicated family liaison officer or chaplain based in the area nearest the family home could inform the family face to face.”

130. I have no doubt that the duty governor and chaplain acted with the best intentions when they decided to wait until 13 July before visiting the man’s son. It was simply unfortunate that his son was not at home when they did visit. I have sympathy with the duty governor’s position and agree that it would be unreasonable to ask him to undertake a long drive after a long and difficult day. However, it is clearly unsatisfactory that the news of his death was first broken to another family member who attended the prison on a visit around 20 hours after the event.

131. Although I intend no personal criticism, my view is that a visit should have been made to the man’s son on the night of 12 July. Such an approach would help to convey that a death in custody is a matter of proper concern to the establishment. If the duty governor was not in a position to make the journey himself then an alternative member of staff should have been asked to accompany the chaplain. If they had then found that the man’s son was not home, they would have had the opportunity to plan an alternative method of contacting the family before his sister’s visit the following afternoon.

**The Governor should ensure that, where possible, the news of a death in custody is broken to the next of kin by a member of prison staff face to face and at the earliest opportunity in accordance with national instructions.**

## RECOMMENDATIONS

1. The head of healthcare should remind prison doctors to record the reasons for any changes to a patient's medication in the patient's medical record.

Accepted – notice to all medical staff to be issued. In addition, locum doctors information folder developed with relevant information contained within.

2. The disability liaison officer should consider alternative arrangements for transporting prisoners with limited mobility around the prison should the wheelchairs on a houseblock be unavailable.

Partially accepted – it is difficult to find alternatives to wheelchairs for those with limited mobility. Crutches are available from healthcare and the number of wheelchairs available in the establishment has been increased.

3. The head of healthcare should ensure that a mobility assessment, to address issues including the collection of medication, is carried out for all prisoners who are noted to have mobility problems.

Accepted – all offenders identified will be referred to the physiotherapist for a formal mobility assessment. Staff have been reminded of the referral pathway.

4. The Governor should remind staff that all instances of bullying should be reported to the violence reduction co-ordinator for investigation.

Accepted – a notice to staff has been published.

5. The system should be established whereby the wing staff alert the violence reduction co-ordinator of those prisoners who might be vulnerable to bullying so that measures can be implemented to ensure their safety.

Accepted – a new violence reduction co-ordinator has been appointed at the rank of senior officer. He will establish ways of identifying those at high risk and provide them with appropriate support.

6. The healthcare manager should ensure that procedures are in place to follow up any hospital discharge letters that are not received in a reasonable time.

Accepted – all offenders returning from hospital will be seen in the first instance by the reception nurse. They will be responsible for ensuring this information is received and will contact the necessary hospital for discharge documentation. The commissioner for offender health is raising this issue with the director of the outside hospital.

7. The healthcare manager should consider the routine measuring of patient blood drug levels where toxicity or non-compliance could exacerbate current medical problems.

Accepted – pharmacy staff are responsible for medication monitoring and advising the clinical team accordingly. Pharmacy staff operate a weekly warfarin clinic, in addition to a weekly nurse led clinic for cardiac patients. The Medical Information System in place also highlights routine testing as required.

8. The Governor should ensure that, where possible, the news of a death in custody is broken to the next of kin by a member of prison staff face to face and at the earliest opportunity in accordance with national instructions.

Accepted in principle – management take seriously the need to inform the family of a death as soon as possible and face to face. In this case there were exceptional circumstances preventing the duty governor from making the necessary trip personally to inform the relatives. However, the establishment will do all possible to speak personally with relatives in a timely manner.