Circumstances surrounding the death a man in hospital, whilst a prisoner at HMP Norwich, in December 2008

Report by the Prisons and Probation Ombudsman for England and Wales

July 2009

This is a report into the circumstances surrounding the death from natural causes of a prisoner at HMP Norwich, in December 2008. He was a French national who had lived in West Africa for much of his life and who spoke little English. He had transferred to HMP Norwich from HMP Blundeston a month before his death but had been taken to hospital the following day. He then remained in hospital until his death. I offer my sincere condolences to his family for their loss.

The investigation was led by my one of my investigators. I must thank the NHS for the appointment of the clinical reviewer. I am also grateful to the Governors and staff of HMP Norwich and HMP Blundeston for the assistance given to my investigator.

The findings of the clinical review have strongly influenced this report. I judge that the man received good quality care whilst at Norwich. However, I am concerned about the use of restraints at the point when it was already known that he was critically ill. I make recommendations regarding the need for prisoners with complex health problems to have co-ordinated care plans, and the need for senior managers' decisions regarding the transfer of prisoners to other establishments to be formally documented.

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Prisons and Probation Ombudsman **July 2009**

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SUMMARY

The man had been remanded into custody in May 2007 and sent to HMP Chelmsford. On arrival in prison, he had an initial assessment and it was established that he did not speak English. His medication was written in French and his medical history was obtained via an interpreter.

On 5 October, the man appeared at the Crown Court and was sentenced to nine years imprisonment together with a recommendation for deportation. He was first sent back to Chelmsford and then transferred to HMP Blundeston on 19 October. On arrival the man said that he felt low in mood, was scared and lonely, and wanted to go back to Chelmsford.

He transferred back to Chelmsford on 14 January 2008, but was not happy and threatened to kill himself if he was not returned to Blundeston within 24 hours. The man was transferred to Blundeston once more on 25 January. He was assessed at reception by a nurse and said that he was now happy with no more thoughts of self harm.

From June 2008 onwards, the man saw healthcare staff on seven separate occasions as he had several episodes of back pain and being generally unwell. He was prescribed pain relief medication. On 10 November, his pain worsened and he looked to have lost weight, although he was not dehydrated. The prison doctor referred him to the local hospital for tests and the results were an unconfirmed diagnosis of cancer. Healthcare informed the wing staff of the potential health difficulties, and also contacted the chaplaincy so that they could offer support to him.

As the man was in chronic pain, Blundeston healthcare staff held discussions with HMP Norwich on 19 November, as Norwich has a 24 hour inpatient healthcare service. He was transferred to Norwich at 7.45pm the next day. Concerns were raised over the lateness of the hour for a journey for someone in his condition.

The man was seen by the doctor the following day (21 November). The doctor recorded that the man had dry skin, was dehydrated and had been vomiting. He referred him to the outside hospital for treatment for dehydration and to monitor his potassium level. A Bedwatch Risk Assessment was completed which authorised that he should be escorted by two officers and a long escort chain should be put in place.

From this date onwards, the man remained in the outside hospital. On 12 December, a prison nurse visited him in hospital and spoke to the consultant. The consultant confirmed that he had cancer in his right lung which was too far advanced for any radiotherapy and chemotherapy treatment. Due to his condition, the nurse asked the duty governor whether the restraints were still needed. It was decided that they should remain in place as the man still had some mobility, but this would be reviewed if his condition deteriorated further.

Prison staff were informed by the hospital on 19 December that the man’s condition had deteriorated significantly in the previous 48 hours and he was now unconscious.

The Governor authorised the removal of the restraints. The hospital informed the prison that the man died on 20 December at 6.00am.

As the man’s wife lives in West Africa, the prison’s family liaison officer contacted the family by telephone and letter. The prison also arranged the services of an overseas funeral director so that the family could hold the funeral in their own country.

I address a number of issues arising out of this investigation. I recommend that Blundeston ensures that prisoners with health problems have co-ordinated care plans, and that senior managers’ decisions to transfer prisoners to other establishments should be formally documented.

THE INVESTIGATION PROCESS

1. My investigator ensured that notices inviting contributions were posted to staff and prisoners about the investigation. No prisoners came forward as a result. My investigator studied all the relevant prison records relating to the man, including his main prison record, medical records, and statements made by staff.

2. The Primary Care Trust asked a reviewer to carry out an investigation of the man's clinical care and I am grateful to her for undertaking this task. My investigator discussed aspects of the man's treatment with healthcare staff at both Blundeston and Norwich and with the clinical reviewer.

3. My investigator also contacted HM Coroner for Norfolk to inform him of the nature and scope of my investigation.

4. One of my family liaison officers made contact with the man's wife in Africa, and with his sons in France (via their chosen representative). The family were offered the chance to raise questions and concerns for the investigation to consider. They did not raise any specific matters but did want to know more about what happened to the man. My report will be made available to the family on completion, having been translated into French.

HMP BLUNDESTON

5. Blundeston is a category C training prison providing a therapeutic community, an assessment unit, skills training and education, and accredited offending behaviour courses. It has a current operational capacity of 526 prisoners, which includes a 40 cell Therapeutic Community Unit.

6. Blundeston does not accept prisoners who have less than 12 months to serve. There is provision for life sentence prisoners. There are no ground floor cells and therefore Blundeston is unsuitable for prisoners unable to climb stairs.

7. The last inspection of Blundeston by HM Chief Inspector of Prisons, before the man's death, was in June 2008. It was an unannounced follow up inspection. The Chief Inspector made the following comments about healthcare:

   "Prisoners generally had good access to health services. The healthcare manager wanted to expand the provision of healthcare services but was hampered by insufficient staff and lack of space. GP cover was satisfactory and prisoners benefited from a wide range of nurse-led clinics and visiting specialists. Mental health services were poor but there were plans to address them.

   "There were no formal nurse triage algorithms. Given the diversity of experience of nursing staff, their assessments could differ greatly in the quality and outcomes. None of the nursing staff had completed any triage courses.

   "Great Yarmouth and Waveney Primary Care Trust (PCT) was not proactive in its involvement with the complexities of prison healthcare. There was no clear evidence that the PCT had embraced the health needs of prisoners in its overall strategy."

8. The Chief Inspector went on to make the following comment and recommendation regarding foreign national prisoners:

   "The Big Word interpretation service was available but we were unable to obtain information about the level of use. We were told by some foreign national prisoners that they had been used as interpreters in confidential situations, such as accompanying prisoners to the healthcare department.

   "I recommend a formal and approved interpretation service should be used, especially in circumstances involving prisoner confidentiality."

9. The prison's Independent Monitoring Board issued its most recent annual report in June 2008. The report made the following overall comment about the prison:

   "Blundeston continues to perform to the highest level, in what are still testing times. The Prison Service has its methods in calculating how well prisons perform and Blundeston has been in the top 10 for the past two years."

10. Since 2004, when I was given responsibility for investigating all deaths in prison custody, there have been no previous deaths at Blundeston.

HMP NORWICH

11. Norwich is a city centre prison, predominantly serving the courts of East Anglia. It has an operational capacity of 557, holding remand and sentenced adult men and young offenders. The prison is divided into two sections. One area accommodates young offenders and the other, with the healthcare centre, is for adults.

12. The healthcare centre provides 24 hour healthcare cover and has space for a maximum of 23 inpatients. On the ground floor of the centre is a specialist elderly patients unit, Nelson Unit. This unit has been designed and equipped to enable older and less able prisoners to be supported and cared for within the confines of the prison environment

13. HM Chief Inspector of Prisons last inspected Norwich in November 2006. The Chief Inspector recognised the good links with palliative care teams and good use of the Liverpool Care Pathway. (The Liverpool Care Pathway (LCP) is a key recommendation in the National Institute for Health and Clinical Excellence (NICE) guidelines for supportive and palliative care. It is a continuous quality improvement programme for the care of a dying patient. It has been developed in order to transfer the hospice model of care into other settings, including prisons. There is a multi-disciplinary document which provides a framework for end-of-life care. The LCP provides guidance on the different aspects of care required, including comfort, pain control and when to discontinue inappropriate interventions. Psychological and spiritual care and family support can also be included.)

14. The man was the ninth death at Norwich that my office investigated during 2008. Of these, four deaths were of prisoners from the Nelson Unit. The man's death is not the first to have occurred when a prisoner has been transferred to the Unit and then quickly moved again to the local hospital.

KEY FINDINGS

15. In May 2007, the man was remanded in custody by the Magistrates Court to HMP Chelmsford. On arrival a First Reception Health Assessment was completed by a nurse. It was recorded that he did not speak English. His medication was written in French and his medical history was obtained via an interpreter. He suffered from hypertension (high blood pressure) and high cholesterol (which causes artery swellings and blockages). He was prescribed Amlodipine (reduces blood pressure), Simvastatin (controls elevated cholesterol levels), Bendrofluaside (treatment of hypertension) and aspirin (a long term low dose to prevent blood clotting).

16. Three days later the man was reviewed by the prison doctor, again in the presence of an interpreter. The doctor recorded that he appeared well and was not pale. The doctor confirmed that he suffered from hypertension and high cholesterol, and that he had a cerebrovascular accident (stroke) in 2001 which had affected the right side of his body. The man's blood pressure was recorded as 144/79. (The normal range for blood pressure is 100/70 to 140/90, varying throughout the day depending on the individual's activities. A blood pressure reading of greater than 140/90 is classed as high and a reading of 90/60 or below is classed as low.)

17. On 31 May, the man was seen by a nurse for a blood pressure check which was recorded as 160/100 and so was a cause for concern. The doctor reviewed him two weeks later and again his blood pressure was high at 160/80. The doctor changed his medication by removing the Bendrofluaside, and increasing the amount of Amlodipine to 10mg. All his other medication remained the same. After a further seven days, his blood pressure was checked again and recorded as 152/95. The man had a further review with the prison doctor on 26 July, when his blood pressure was recorded as 154/89. He was prescribed Ramipril (for treatment of hypertension) as well as his existing medication.

18. The man appeared at the Crown Court on 13 August and was remanded to HMP Peterborough. On arrival, he had another medical review with the prison doctor who confirmed his health conditions and medication. During the following two weeks, he was seen by a nurse three times and his blood pressure was checked on each occasion. His blood pressure was recorded as 152/105, 170/99 and 124/81.

19. On 5 October, the man appeared once more at the Crown Court and was sentenced to nine years imprisonment together with a recommendation for deportation. He was sent to HMP Chelmsford and, on arrival, had a further reception health assessment that confirmed his health conditions and medication. A week later he was seen by the prison doctor as he was complaining about pain in his right hip. The doctor recorded that his blood pressure was 130/80 and prescribed senna (a laxative) in addition to his existing medication.

20. The man transferred to HMP Blundeston on 19 October. On arrival he was seen by a nurse who completed an initial health assessment and confirmed the

medication he was taking at Chelmsford. A single cell was requested which was to be no higher than the first landing so that he would have no need to climb many stairs. Three days later the man was seen by a member of staff from the Mental Health Inreach Team. An interpreter was present. He said that he felt low in mood, was scared and lonely, and wanted to go back to Chelmsford.

21. During the following two weeks the man's blood pressure was checked three times by a nurse and recorded as 169/87, 140/90 and 142/87. On 9 November, he had a medical review with a doctor which was also in the presence of an interpreter. The doctor checked and repeated the man's medication and recorded that his blood pressure was 124/80, which is within the normal range.

22. The doctor saw the man again on 23 November as he was complaining about constipation. The doctor prescribed Lactulose (laxative syrup). The doctor recorded that his right leg was swollen with signs of varicose veins, and he arranged for compression stockings to be provided. Two weeks later, the man was seen by a nurse and said that his leg was now much better since he had been wearing the stockings. His blood pressure was again recorded as within the normal range.

23. On 14 January 2008, the man returned to Chelmsford. He was assessed by the reception nurse and said that he was not happy with the transfer. He threatened to self harm and kill himself if he was not taken back to Blundeston. (This was despite the fact that he had himself requested the transfer back in October 2007.) His medical history and current medication were confirmed and an Assessment, Care in Custody and Teamwork (ACCT) document was opened for him. (The ACCT process is designed to support and monitor prisoners assessed as at risk of harm to themselves.)

24. The next day the man was reviewed by the prison doctor. He was in an emotional state, and was agitated and anxious. He repeated that he would kill himself and refused to be examined by the doctor. He did agree to his blood pressure being checked (it was recorded as 124/98). The doctor confirmed that the man would continue to take his existing medication and told him that he would try to arrange a transfer back to Blundeston. There is no record to show whether interpreters were used on this occasion. The ACCT document remained open as he was still thought to be at risk of self harm.

25. The man transferred back to Blundeston on 25 January where he was seen at reception for a health assessment by a nurse. His weight was recorded as 85kg and his blood pressure was 157/95. He said that he was happy about coming back to the prison and had no more thoughts of self harm. The ACCT document was closed as it was assessed there was no current risk of him harming himself. The following day, he was seen by the prison doctor. The doctor authorised that he should continue to take his existing medication.

26. On 2 June, the man saw another doctor because he had pain in his left shoulder. The second prescribed paracetamol (for relief of minor aches and pains). He also authorised a repeat prescription for the rest of the man's medication. He was next seen by a third doctor a month later on 2 July as he was experiencing

pain in his lower back. The third doctor prescribed ibuprofen (for moderate pain relief and acting as an anti-inflammatory) as well as more paracetamol. The man's blood pressure was recorded as 120/70.

27. By 28 August, the man was still experiencing pain in his back and left leg. He was seen by the first doctor who recorded that, on examination, there were no signs of swelling. He prescribed co-codamol (a combination of codeine and paracetamol for strong pain relief) and Voltarol cream (an anti-inflammatory and for pain relief). The man was next seen on 16 September by a fourth doctor as he was still experiencing pain. He diagnosed trochanteric bursitis (an inflamed and tender muscle at the top of the leg close to the hip), and prescribed Diclofenac (non-steroidal anti-inflammatory drug). The fourth doctor recorded that the man should be reviewed in two weeks time, with the possible need for an x-ray. The fourth doctor noted that the man had limited command of English but there is no evidence as to whether an interpreter was used.

28. A medical review was conducted on 30 September and a fifth doctor recorded that the man was still in pain. The doctor arranged for him to have a steroid injection. The fourth doctor administered a Depomedrone injection (an anti-inflammatory steroid) on 15 October. The fourth doctor saw the man two weeks later to review the effects of the injection and the man said that he was in less discomfort. The fourth doctor made a referral to the local hospital for x-rays.

29. A week later, the man saw the fifth doctor as he had a slight wheeze and was producing yellow sputum. The fifth doctor prescribed Amoxicillin (an antibiotic used to treat bacterial infections) for five days. He also recorded that there was tenderness on the right side of the man's chest. A date for the x-ray was still awaited.

30. On 10 November, healthcare staff received a telephone call from the man's prison wing to say that they were concerned about his health as he was not going to collect his meals. A fourth doctor saw him at 10.18am and recorded that his pain was worse and he looked to have lost weight, although he was not dehydrated. There is no evidence to show whether his weight was recorded or that a plan was put into place to monitor his weight.

31. The fourth doctor telephoned the hospital as the x-rays had not been carried out. He was told that they could only be done urgently if a patient attended the emergency department. The man was sent to the emergency department and returned to the prison later the same day.

32. The next day (11 November), the x-ray results were received. They showed a suspicious lesion (tumour) on the man's right lung, and the hospital suspected that he had cancer although the diagnosis was not confirmed. The x-ray of his hip was normal. The third doctor with an interpreter saw the man to tell him of the results. The man said that he had been a smoker but had given up some eight years earlier. A nurse informed the wing staff about his potential condition, and contacted the chaplaincy so that they could offer support.

33. On 13 November, the MacMillan Cancer Support Nurse contacted healthcare to arrange a visit to the man on 17 November. However, the visit did not take place as the MacMillan nurse was absent due to sickness. There is no record of alternative arrangements being made.

34. The fourth doctor saw the man on 19 November as the pain was now affecting his sleep. The doctor prescribed Oramorph (morphine formulation for chronic pain relief). Blundeston healthcare staff initiated discussions with their counterparts at HMP Norwich to arrange to transfer the man to the Nelson Unit (the palliative care unit which is supported by a 24 hour healthcare service). Blundeston agreed to provide staffing for any escort duties following the man's transfer.

35. The man was transferred to Norwich at 7.45pm on 20 November. A review of his clinical record was completed by the head of healthcare and a qualified nurse. She recorded that there was no confirmed diagnosis of cancer and no suggestion of metastases (spread of a disease from one organ to another). However, she was concerned about someone in the man's condition being transferred to another prison so late in the day. In addition, his prescription chart had not been transferred from Blundeston, which meant that healthcare staff at Norwich were unable to give him the correct pain relief medication.

36. The man was seen by a sixth doctor the next day, at 10.33am. The doctor recorded that he was not sleeping, was losing weight, and had no appetite, but there were no signs of acute ischaemia (restriction in his blood supply). A letter had been received confirming that a Computed Tomography (CT) scan had been arranged for him on 24 November. (The CT scan takes a series of x-rays of the body at slightly different angles, to produce very detailed pictures of the inside the body. The pictures produced by CT scans are called tomograms and they provide doctors with information to help them reach a diagnosis about a variety of conditions.)

37. Later at 3.42pm, a seventh doctor saw him. He recorded that the man's blood pressure was 100/80 and his weight was 60.32kg. He had dry skin, was dehydrated and had been vomiting. He referred the man to an outside hospital for treatment for dehydration and to monitor his potassium level. A Bedwatch Risk Assessment was completed and it was decided that he should be escorted by two officers, with the use of the escort chain. (An escort chain is a long length of chain with a single handcuff at each end. One cuff is attached to the wrist of prisoner, and the other is attached to the wrist of a prison officer.)

38. From 21 November onwards, the man remained in the outside hospital. On 12 December, the head of healthcare visited him and spoke to the hospital consultant who confirmed that he had cancer in his right lung. By this stage, the cancer was too far advanced for any radiotherapy and chemotherapy treatment. The head of healthcare recorded that the man remained very unwell and had a syringe driver in place to manage his symptoms. Due to his condition, the head of healthcare asked the duty governor whether the escort chain was still required. As the man still had some limited mobility, the duty governor decided

that the restraint should remain in place but would be reviewed if his condition deteriorated.

39. Whilst he was at the outside hospital, the hospital staff arranged for the man to be allowed to use the telephone to speak to his wife and family. Hospital staff also kept his family informed of his condition.

40. The head of healthcare was told by the hospital on 19 December that the man's condition had deteriorated significantly in the previous 48 hours and he was now unconscious. The information was passed to the Governor of Norwich who authorised the removal of restraints, which also meant that the bedwatch officers were no longer required. At 7.15pm the same day a governor grade visited the hospital and issued the licence to release the man on compassionate grounds. The hospital informed the prison that he had died on 20 December at 6.00am.

41. As the man's wife lives in West Africa, the prison's family liaison officer contacted the family by telephone and letter. The prison also arranged the services of an overseas funeral director to send his body to West Africa so that the family could hold the funeral in their country. The prison met these costs.

ISSUES

Communication with the man

42. The man was a French speaker with a limited command of English. It was identified throughout his time in prison that the language barrier meant that communication was an issue. However, during 18 months in prison, the records indicate that he was only helped by an interpreter on five occasions, and translation was facilitated by a fellow prisoner one further time. There is evidence to suggest that using an interpreter would have facilitated his medical consultations and helped allay his fears.

    The Governors of Norwich and Blundeston and relevant Primary Care Trusts should remind staff of the translation facilities available to assist during healthcare consultations.

Clinical care

43. The clinical reviewer highlights that during the period from July to November 2008, the man had 14 consultations with five different prison doctors. He did not see the same doctor consecutively at any time apart from between 30 September and 6 October 2008 when he was seen by the fourth doctor.

44. The man's weight was recorded as 85kg on his return to Blundeston on 25 January 2008. The clinical reviewer comments that by 21 November, some ten months later, his weight had dropped to 60.32 kgs. This is a loss in weight of some four stone whilst he was at Blundeston. There is no record of his weight loss having been noted or a plan being put in place to monitor his weight, despite the observation and recording that he had not been collecting meals.

    The Healthcare Manager at Blundeston should review the systems to monitor a prisoner's nutritional status when concerns are raised to make sure that the nutritional needs of identified prisoners are met.

45. There appears to have been limited liaison between healthcare staff at Blundeston and the local hospital in arranging x-rays for the man. Though the delay is unlikely to have had an effect on his prognosis, there was a gap of three weeks between the referral and when he eventually went to the emergency department to have the x-rays taken. There should be more effective liaison between healthcare staff at Blundeston and the PCT to ensure appropriate and timely health services that meet prisoners' needs.

    The Healthcare Manager at Blundeston should develop an effective partnership with the PCT to ensure that prisoners with health problems have a coordinated single case management plan.

46. An unconfirmed diagnosis of cancer was made on 11 November, and MacMillan Cancer Support contacted Blundeston to make arrangements to visit the man on 17 November. The appointment was not kept due to sickness, and there is no

record of any follow up contact being made. Within three days he was transferred to Norwich.

47. Concerns were raised by staff at Norwich as to the timing of the man's journey and his medical condition. There was no documentation to suggest that he was properly assessed and his fitness for transfer approved or that this was communicated to Norwich. No medication chart was available to the nursing team at Norwich as it had not been sent with him. The outcome was that staff were unable to give prescribed pain control, and an on-call doctor had to be called which resulted in an unnecessary delay before he received the correct medication.

48. The man was at Norwich less than 24 hours before being referred to hospital. This raises the question as to whether it would have been more appropriate to have referred him to hospital directly from Blundeston.

The Governor and Healthcare Manager of Blundeston should review the procedures for transferring prisoners to ensure that adequate assessment has been completed and prescription charts and medication are all available, especially when transferring outside normal hours.

49. The clinical review highlights good practice by Norwich staff who made sure that appropriate assessment and care was delivered to the man. The review also draws attention to the good communication with him whilst he was in hospital and the fact that care was taken to make his family aware of his condition.

Use of restraints

50. When there are any changes to a prisoner's circumstances, a new risk assessment for the bedwatch requirements should be undertaken. Although it was known on 12 December 2008 that the man was terminally ill, there was no change to the documented risk assessment.

51. In April 2008, all Governing Governors and Heads of Groups were sent a written communication from the Head of Security, National Offender Management Service. It provided a summary of two judicial reviews concerning the risk assessment procedures for hospital escorts and bedwatches, with particular emphasis on the use and application of restraints. Specifically the summary states that:

"The Judgment …

- Makes the distinction 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. Medical opinion regarding the prisoner's ability to escape must therefore be considered as part of the assessment process.

- Deems the restraining by handcuffs of a prisoner receiving chemotherapy (and, by implication, other life saving treatment) degrading. Such restraint

would be likely also to be regarded as inhumane unless justified by other relevant considerations.

- Requires that each decision is properly considered taking account of all relevant information and be proportionate to the risks involved.

- Requires a fresh risk assessment to be conducted each time it is reviewed in order to establish: the level of restraints to be used during transportation to and from the hospital and the level of restraints to be used during the prisoner's stay in hospital."

52. In light of this advice, senior managers at Norwich could have considered changing the man's bedwatch arrangements from 12 December onwards. At this point there was a significant change to his circumstances as the diagnosis of terminal cancer had been confirmed. The head of healthcare had raised the matter with the duty governor and asked about the need to continue using the restraints and bedwatch. The decision was that the restraints should remain in place.

53. I fully understand that decisions concerning the appropriate use of restraints involve the balancing of competing objectives. Both public protection and the reputation of the Prison Service rely upon the Service's admirable achievements in recent years in reducing the numbers of escapes. Risk assessment is a matter of fine judgement, and it is an inexact science at the best of times. However, this is far from being the first report when I have observed that in a less risk adverse climate, very different decisions about the use of restraints might reasonably have been made. I do not criticise the decisions taken by Norwich, given the prevailing climate and the expectations of the Service as a whole. However, I do take this opportunity of reminding the Governor of Norwich of the terms of the note issued by the NOMS Head of Security in April 2008.

RECOMMENDATIONS

1. The Governors of Norwich and Blundeston and relevant Primary Care Trusts should remind staff of the translation facilities available to assist them during healthcare consultations.

2. The Healthcare Manager at Blundeston should review the systems to monitor a prisoner's nutritional status when concerns are raised to make sure that the nutritional needs of prisoners are met.

3. The Healthcare Manager at Blundeston should develop an effective partnership with the PCT to ensure that prisoners with health problems have a coordinated single case management plan.

4. The Governor and Healthcare Manager of Blundeston should review the procedures for transferring prisoners to ensure that adequate assessment has been completed and prescription charts and medication are all available, especially when transferring outside normal hours.

   At the time this report was issued there has been no response from the prison service to the above recommendations.