

**Investigation into the circumstances surrounding  
the death of a man  
in March 2011 at HMP Norwich**

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

**December 2011**

This is the report of an investigation into the circumstances surrounding the death of a man, a prisoner at HMP Norwich. He died in March 2011. He was 79 years old. The cause of death was recorded as cancer of the rectum.

I extend my condolences to those affected by the man's death. I hope that my report goes some way to answering any questions his family may have. I regret that my report has been delayed and apologise for any additional distress that this may have caused to his family.

The investigation was carried out on my behalf by my colleague. The local Primary Care Trust (PCT) commissioned a clinical review into the standard of healthcare the man received whilst in custody from a clinical reviewer.

The man was already ill when he arrived at Norwich. Some months later, he was diagnosed with cancer and it was agreed that he should be treated palliatively as the cancer was not suitable for chemotherapy or radiotherapy. He received appropriate healthcare at Norwich, including appropriate end of life care before he died.

I make four recommendations as a result of the investigation. These concern ensuring the most up to date approach to end of life care, ensuring the availability of out of hours prescriptions and properly considering and recording applications for compassionate release in cases such as the man's. The clinical reviewer also makes several recommendations in her review, and I commend these to both the Governor and Head of Healthcare at HMP Norwich.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

**Nigel Newcomen CBE  
Prisons and Probation Ombudsman**

**February 2012**

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## SUMMARY

1. The man was first remanded into HMP Norwich on 5 January 2010. charged with serious offences. He subsequently received a ten year sentence and was accommodated on “L” wing, a wing dedicated to older prisoners that is situated on the ground floor of the healthcare centre.
2. He had a number of ongoing medical issues which were addressed by the prison’s healthcare centre and through appointments at hospital. During one of his admissions to hospital in May, biopsies were taken. In June, he was diagnosed with cancer.
3. The nature of the man’s condition meant that he was not suitable for chemotherapy or radiotherapy. Care was provided on a palliative basis on “L” wing, with pain relief administered as required. Although there was some discussion about compassionate release, it was unclear exactly what steps were taken and how this was managed by the prison. In March 2011, end of life care was implemented, using the Liverpool Care Pathway, to support him. His health continued to deteriorate as the illness progressed, and he passed away on 24 March.
4. There are four recommendations as a result of the investigation. These concern end of life care, the availability of out of hours prescriptions and the consideration of compassionate release. The clinical reviewer also makes several recommendations in her review, and these are commended to both the Governor and Head of Healthcare at HMP Norwich.

## THE INVESTIGATION PROCESS

5. The investigation into the man's death was opened by a senior investigator. Notices were issued to staff and prisoners at Norwich informing them of the investigation and inviting them to contact the investigator should they wish to talk to him regarding the investigation. No-one came forward in regard to the notices.
6. An independent clinical review was undertaken on behalf of the local PCT by a clinical reviewer. We rely heavily on her findings in arriving at our own, and are grateful for her review, which was completed in September 2011. I regret that late receipt of the clinical review, as well as workload pressures in this office, delayed the issue of the report.
7. A family liaison officer from this office contacted the man's wife and explained the remit and purpose of the investigation, providing her with the opportunity to raise any questions or concerns she may have had. She commented on the care her husband received at Norwich as follows:
  - He was said to have been very depressed as a result of his illness, although his wife felt there was possibly little that could have been done to help him in this respect.
  - She mentioned he had generally seemed content with the healthcare he was receiving and had not mentioned anything of particular concern. When asked, he would say everything was okay and that staff were being good to him.
  - A number of food items (for example, noodles) were returned among his property, which suggested he would have been expected to prepare his own meals. His wife felt he would have found this difficult, particularly given his depressed state and asked whether this could be clarified. She is concerned he may not have eaten properly as a result.
  - She spoke positively about the help and support she had received from the prison following his death. She confirmed the prison had assisted with funeral arrangements and costs and that his property had been returned.
8. As part of the consultation period, the man's wife received a copy of the draft version of this report. In her feedback, she commented that she was reassured to find that the food items returned with her husband's belongings were surplus and that he had not gone without regular meals. She said her husband had been ill for many years and she accepted that his death was the result of natural causes. No further issues were raised.
9. The investigation assesses the following aspects of the man's care and treatment:
  - Whether his diagnosis was made in a timely fashion.
  - Whether he was told about his condition and the treatment which followed.
  - Whether he was treated properly and attended hospital appointments as necessary.
  - Whether the liaison with the family was appropriate.

- Whether he was accommodated in the most appropriate part of the prison.
- Whether consideration was given to compassionate release from prison.
- Whether appropriate palliative care was provided.

## **HMP NORWICH**

10. HMP Norwich is a local training prison serving the courts of Norfolk and Suffolk. It holds a maximum of 767 men, a mixture of adults and young offenders. The original buildings date back to the Victorian era and the site is geographically split into two locations. It also has a dedicated older prisoners' unit (L wing) for those with chronic or terminal illnesses.

### **Healthcare**

11. Healthcare services are commissioned by NHS Norfolk and provided by a private company, Serco Health, which also provides healthcare at two other nearby prisons. Serco delivers the care in association with a number of partners, including Norfolk Community Health and Care (NCH&C). Close links have been developed with the Priscilla Bacon Lodge, an NHS facility located in Norwich which specialises in the care of those prisoners reaching the end of their lives. The healthcare service provided at the prison consists of:

- primary medical and nursing services
- out of hours and 24 hour nursing cover
- mental health in reach services
- community services
- dentistry
- in patient care unit
- life sentence prisoner inpatient unit.

### **“L” wing older prisoners’ unit**

12. “L” wing caters for 15 patients, all of whom are over 65 years old. During the day, a registered nurse is always on duty, while nights are staffed by a registered nurse from the healthcare centre. There is also a healthcare assistant on duty and a prison officer trained in healthcare duties. All the cells in the unit are adapted for wheelchairs and have en-suite facilities. Patients can have a specialist hospital bed if they need one.

### **Her Majesty’s Inspectorate of Prisons**

13. Her Majesty’s Inspectorate of Prisons reports on all Prison Service establishments. In February 2010, the Inspectorate carried out an unannounced inspection at Norwich and the resulting report was published in April 2010. The inspection found that the managers had tried to focus on the prison’s local role and organise the accommodation in a more effective way. The environment had been greatly improved by rebuilding A Wing. The report concluded that Norwich was an improved and safer prison compared to the last time they had visited in 2007.
14. The Inspectorate report also refers to the dedicated older prisoners’ unit. Inspectors found that many of the patients required full nursing care and staff struggled to provide the required level of care. Staff had not received specific

training in dementia. However, patients who were spoken to were satisfied with their care.

15. The inspection found that the healthcare provision was improving but the inpatient regime was insufficient. The report made the following comments about the older prisoners' unit in particular:

“Many of the patients required full nursing care and staff were hard pushed to provide the required level of care despite their best efforts.

“The unit had excellent links with outside agencies, including the local palliative care team.”

### **Independent Monitoring Board**

16. Each prison has an Independent Monitoring Board (IMB) whose role is to monitor the prison and to report any concerns that they have regarding the prison, or how prisoners are treated. Board members visit any area of the prison at any time and have direct access to any prisoner who they wish to see, or who asks to see them. The Board holds regular meetings in the prison, with the Governor attending for part of the meeting. The Chair of the Board produces an annual report to the Secretary of State for Justice.
17. The latest annual report, for the period 1 March 2009 to 28 February 2010, said:

“Currently, there is a tendering process [for healthcare provision] taking place, the outcome of which is unknown. It is hoped that this will address the longstanding problem of being provided with locum doctors, who can be unfamiliar with a prison healthcare setting.”
18. The report said also that the position for elderly prisoners had not improved over the last year in relation to social care. It said the prisoners on the older prisoners' unit had very little with which to occupy themselves and that providing specialist diets can be problematic.

### **Previous deaths in custody at Norwich**

19. Since the Ombudsman took responsibility for investigating deaths in custody in April 2004, there have been 44 deaths at Norwich, of which 26 were due to natural causes. Several issues relating to the care of people with terminal illnesses have been raised before, and these are highlighted in the clinical review. In addition, the clinical reviewer previously made a recommendation about the provision of mental health services for elderly lifer prisoners. The issue is covered as part of this report.

## ISSUES

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

20. The man was remanded into HMP Norwich on 5 January 2010. He had a complex medical history, having suffered from cancer of the rectum in 1995, which led to complications such as pelvic abscesses, an abdominal disorder caused by radiation treatment, and the need for a catheter (a tube to drain urine from the bladder) and a colostomy bag (which provides an alternative channel to the rectum for faeces to leave the body). He also suffered from a kidney disorder and depression, and used a wheelchair.
21. During the man's reception health screening, his various medical conditions were recorded in his medical record. He signed a disability induction questionnaire, informing staff that he had reduced mobility and a reduced physical capacity. He was, however, able to care for himself. He made staff aware that he had outstanding outpatient appointments at Ipswich Hospital for a supra pubic catheter (a catheter which exits via the abdomen) to be inserted into his bladder, to have a kidney bypass and for a blood test to check for anaemia. These were noted in his medical record so that they could be re-arranged. A report written by his community doctor was available for staff to see and information within the report was recorded in his medical record.
22. The man was accommodated on "L" wing, a dedicated unit for older lifer prisoners that is situated on the ground floor of the healthcare centre. The wing has a nurse present at all times and officers are trained in healthcare procedures. The cells are adapted for wheelchair users and have en-suite facilities.
23. A doctor reviewed the man the following day. He was said to be alert and orientated and his chest was clear, although he reported some pain in his left kidney area. A dipstick test was done to determine if he had a urinary tract infection. Some blood was present in his urine and he was prescribed antibiotics. A nurse attempted to complete an assessment of his needs and nutrition, but he was tired and went to sleep.
24. The assessment was completed on 7 January. The man was prescribed Fortisip nutritional drinks (a high calorie ready made milkshake type drink) to help maintain his weight, as he suffered from abdominal pain when he ate solid foods and had a poor diet intake.
25. Between January and April, the man received ongoing treatment for his various medical conditions, and attended hospital on a number of occasions. This included treatment relating to the function and maintenance of his catheter.
26. On 5 May, nursing staff noticed that the man looked very unwell and was experiencing abdominal pain. A nurse assessed him and referred him to the doctor. He was examined by a doctor at 9.10am, who noted in his medical

record that he was also vomiting and his vomit had contained bile and faecal fluid. An ambulance was called and he was admitted to hospital.

27. The nurse made an entry in the man's medical record on 7 May. She said that he was on a ward and was having an operation that day and it was not known when he would be fit for discharge. More would be known about his plan of care the next day once the operation was complete. Hospital staff were not able to say what procedure he was going to have.
28. The man was discharged on 10 May. While in hospital, he had a new catheter inserted as well as an evacuation of the rectum. Biopsies were also taken of his peritoneal fluid (space between abdominal wall and internal organs) and rectum. Staff were informed that they should flush his catheter twice a day using sterile water to prevent blockages.
29. The man was diagnosed as having another urinary tract infection on 11 May. He was prescribed antibiotics by the doctor. His medical record shows that his catheter was being flushed by healthcare staff as recommended by the hospital. He was examined by the doctor again on 19 May. He was suffering from a chronic urinary tract infection, with urethral discharge and pus present in his catheter bag. He was prescribed further antibiotics. His weight was also recorded that day as 63kg, an increase of 3kg since April.
30. The man was reported to be feeling much better on 26 May. The urine he had passed was said to be brown in colour and offensive smelling. His bowel contents had a lot of blood and debris in it. He saw the doctor the following day, who noted that he was generally well and did not have a fever. The doctor did a dipstick test of his urine and prescribed antibiotics for another urinary tract infection.
31. The doctor made an entry in the man's medical record on 8 June. He wrote that the biopsies taken in hospital the previous month had shown cancerous cells. He was not suitable for chemotherapy or radiotherapy because his condition was too advanced for such treatment to have any chance of success. He was instead to receive palliative care. The doctor advised that the man was not aware of this information at that time.
32. On 15 June, the doctor discussed the biopsy results with him and explained the palliative care that he would receive.
33. The clinical reviewer comments that the man was aware that he had a carcinoma before he came into prison. In our opinion, the diagnosis of further cancer was timely and appropriate. He complained of abdominal pain on 5 May, and was admitted to hospital promptly, where the diagnosis was made.

### **Informing the man about his condition and treatment**

34. The man had a complex medical history, having suffered from cancer of the rectum in 1995. This led to complications such as pelvic abscesses, and an

abdominal disorder caused by radiation treatment and the need for a catheter and a colostomy bag.

35. The Palliative Care Nurse visited the man on 11 March 2010. She explained the results of a CT scan (computerised tomography, a scan which uses x-rays to build up an image) which showed he had a pelvic mass that was inseparable from his rectal stump (part of the rectum left in place after surgery). She said that the mass may have been an abscess, but the possibility that it was a recurrence of a tumour could not be excluded.
36. The man was admitted to hospital in May, and biopsies were taken. On 8 June, the doctor noted in the clinical record that his biopsies had shown that cancerous cells were present. One week later, the doctor told him that cancer cells had been found in his biopsy samples and that he was not suitable for treatment, but would receive palliative care. It was noted that he accepted this information and asked about his prognosis. The doctor told him that he had a 50% chance of surviving five years and a 20% chance of surviving ten years.
37. In her clinical review, the reviewer noted that the man was fully informed about his condition, the inappropriateness of aggressive (meaning chemotherapy or radiotherapy) treatment, and the nature of palliative care.

#### **The man's medical appointments and treatment**

38. The nature of the man's diagnosis meant that he was not suitable for aggressive treatment of his condition. His appointments at hospital were, therefore, for other medical issues rather than specifically for the treatment of his cancer.
39. During July 2010, the man's hospital appointments were changed on a number of occasions. This was due to problems with escorting staff and cancellations made by the hospital. However, these appointments were re-scheduled without long delays.
40. On admission to hospital in August, the man was told that there were no further medical interventions that he could receive. Instead, he would receive palliative care and pain relief in the prison.
41. The man's care was adequately provided on "L" wing. He did not have any outstanding hospital appointments, although he had several emergency hospital admissions, during which the care he received was appropriate.

#### **The man's pain relief and medication**

42. Following his diagnosis, the man's palliative care was managed on "L" wing. In her review of the clinical care, the reviewer wrote that the palliative care unit is supported by the in-reach team from Priscilla Bacon Lodge (a centre in Norwich providing specialist palliative care), and prescribing (of medication for pain relief) is recommended by the palliative care consultant or specialist nurse.

43. In general, the man's pain was managed appropriately. He was prescribed pain relief when required, and had assessments for further input such as physiotherapy. The maintenance of his catheter and associated pain relief, skin irritation and soreness were also considered.
44. The man did not receive medication for the treatment of his cancer as this was not deemed appropriate. In addition to pain relief, he was prescribed antibiotics for urinary tract infections on a number of occasions.
45. The clinical reviewer wrote in her clinical review that on occasion, ongoing prescriptions for the man's medications were not rewritten because a doctor had not attended the wing on that day. On one occasion, nursing staff contacted the out of hours GP service, but the on-call doctor refused to attend the prison and issue a prescription because they had not received a call earlier in the day to request it. It was not clear what action was taken to ensure that the situation did not arise again. She wrote that there did not appear to be an agreed protocol with the out of hours service to address the issue.
46. It is important that, when a prisoner is receiving palliative care, staff can access appropriate pain relief when it is required. The clinical reviewer makes a recommendation in her clinical review on this subject. We make the following recommendation:

**The Head of Healthcare should ensure that out of hours prescriptions can be obtained when needed**

#### **The man's location and compassionate release**

47. When the man was diagnosed with cancer in June 2010, he told the doctor that he wanted to pursue an application for compassionate release. The doctor advised him that this would be more appropriate when his condition became more advanced and deteriorated further.
48. A nurse made an entry in the man's medical record on 31 July that a prison cell may not have been the most appropriate place to provide him with care at that time. He was examined by a doctor, who found that his condition had declined. It was decided that advice would be sought from the healthcare manager after the weekend as to the most appropriate accommodation for him.
49. A doctor made an entry in the man's medical record on 13 January 2011 that, during an examination of his dressings and tubes, he said that he wanted to be close to his wife at the end of his life. The doctor noted that he would see him again the following day to discuss this with him. There is no evidence within his prison documentation that suggests the doctor visited him.
50. Another doctor wrote a letter regarding the man's care on 9 February. She said that she had reviewed him and the best management plan was to treat him on "L" wing, with the support of staff from Priscilla Bacon Lodge, if he

developed complex symptom control issues. His main wish was to be near his wife. The doctor had spoken to the residential governor about the possibility of compassionate release. She said in her letter that the governor had agreed to look into the option. His prognosis was thought to be in the region of weeks to months. As compassionate release can be a lengthy process, it would have been an appropriate time to discuss the process with him with a view to starting it, if he wished. There is no evidence within his records to show that any further consideration was given to compassionate release.

51. Although there were various entries in the man's prison documentation relating to compassionate release and where the most appropriate accommodation for him might be, there does not appear to have been any decision made. While the decision whether a prisoner is granted compassionate release is a matter for the relevant authorities, it is important that prisons take steps to ensure that they consider whether they should make an application. It is not clear whether this happened on this occasion, and we therefore make the following recommendation.

**The Governor should ensure that compassionate release is considered on each occasion when it might be appropriate, and that details of the considerations are noted in both medical and prison records**

52. Appropriate accommodation was provided on "L" wing. The man's care needs were adequately met by staff, and extra resources were obtained to ensure his comfort. Medical staff were available at all times throughout the day and night, and adequate resources were provided for his needs.

### **Care plans and palliative care**

53. The man did not receive chemotherapy or radiotherapy following his diagnosis. His care was, therefore, of a palliative nature from June 2010 onwards.
54. He lived on "L" wing, a specialist unit, and received pain relief as required. He had regular reviews with palliative care nurses. A palliative care nurse specialist reviewed him on 21 March. She said he had deteriorated over the previous few weeks and staff had reported a significant deterioration over the past 24 hours. He was barely rousable and was uttering a few inaudible words. He was not distressed, but had a poor fluid intake and was not taking any diet. It was agreed to start to Liverpool Care Pathway for him (the Liverpool Care Pathway outlines the care to be given to a dying patient) and all relevant documentation was completed. It was noted that a Senior Officer would be contacting the man's wife to let her know the change in his condition and the care they were providing. His oral medications were stopped and it was said that he may need a syringe driver (a mechanical device which administers medication) as his condition changed.
55. Care plans were implemented which ensured that the man's care needs were met. The care plans outlined his needs. Each need was then broken down to show staff how they could be met. As his condition deteriorated and his needs

changed, the care plans were amended appropriately. There was strong communication with the palliative care team, who regularly met with and reviewed him. All relevant information was noted in his medical record ensuring that staff were able to keep up to date with his changing care needs.

56. The man's treatment was discussed with him by the palliative care nurse and he was provided with the opportunity to ask any questions he may have had. When his condition deteriorated, the Liverpool Care Pathway was implemented and followed appropriately. The clinical reviewer recommends in the clinical review that, although the Liverpool Care Pathway was followed, it would be appropriate for HMP Norwich to have a care pathway that was specific to the secure environment of a prison, while providing a level of care that could be expected in the community. Since she completed her clinical review, national guidance on the end of life care in prisons has been released by the NHS (it is entitled "The Route to Success in End of Life Care: Achieving Quality in Prisons and for Prisoners"). We make the following recommendation:

**The Governor and Head of Healthcare should ensure that the provisions of "The Route to Success in End of Life Care" have been implemented successfully**

#### **Liaison with the man's family**

57. On 3 November, an officer noted in the electronic record that the man had been visited by a researcher regarding quality of life in prison. During the questions he had become upset and talked about suicide. The officer went to see him, who told him he had no intention of suicide and had been thinking of his previous life with his wife. He wondered how she would be coping alone. The officer reminded him that he could always talk to members of staff and, if he wanted a visit from his wife, could use the assisted prison visits scheme for help. He gave him a leaflet containing information on assisted visits, so that he could read it and speak to his wife. He said he would be grateful for help.
58. A visit from the man's wife was facilitated in healthcare on 11 December. This gave him an opportunity to speak with his wife about his condition and prognosis. The visit was arranged for healthcare to make it as easy as possible for him, and was said to have gone well.
59. The man was started on the Liverpool Care Pathway on 21 March. It was noted that a Senior Officer would be contacting the man's wife to let her know the change in his condition and the care they were providing. However, there is no further evidence within his documentation to show whether this was facilitated or by whom.
60. The man's condition deteriorated a few days later. The safer custody manager telephoned the man's wife, with the intention of explaining the situation and arranging a visit if required. However, there was no reply. She left a message asking her to contact the prison. He passed away at 1.40pm, before anyone from the prison had managed to make contact with his wife.

She travelled to the man's wife's house to inform her that her husband had died and to offer support.

### **Restraints, security and bed watch**

61. The majority of the man's care was adequately provided on "L" wing, and he did not attend many hospital appointments. However, during any hospital consultations that he did attend, he was escorted by two officers, using handcuffs. This was in line with the security policy, although restraints could be reduced during medical procedures if necessary and he was able to be restrained using an escort chain (a long chain with a cuff at either end) while an inpatient at hospital. Appropriate risk assessments were made prior to hospital appointments and during hospital admissions. The personal escort records and bed watch log entries were made to a good standard and were legible. At the time of his death the open door policy was in place, allowing staff unrestricted access to be able to meet his needs and provide medical care.

### **Issues raised by the man's family**

62. The man's wife told our Family Liaison Officer that she thought he was depressed, but she was unsure exactly what could have been done. There is evidence to suggest that he was, at the very least, understandably unhappy about his situation, both in terms of his imprisonment and his illness. Although he received support from various members of staff on a range of issues, it does not appear that there was any formal intervention in terms of addressing any mental health needs that he might have had.
63. The clinical reviewer identified that, according to his medical record, the man did not receive any mental health input whilst at Norwich. She commented that mental health provision for older prisoners at Norwich was "not well developed" and it was difficult to understand how prisoners on "L" wing accessed or were referred for these services. We agree and make the following recommendation:

**The Head of Healthcare should ensure that the mental health needs of older prisoners at Norwich are identified and that an appropriate service is developed to meet these needs.**

64. The man's wife was concerned that the property returned to her after her husband's death included a number of food items. This suggested that he might have been expected to prepare his own meals and could have struggled with this. Whilst living on "L" wing, he would have received prepared meals in the same way as other prisoners. He would not have been expected to prepare his own. He would have been able to order food items from the prison 'shop' and these would have been in addition to the prepared meals that he received.

## CONCLUSION

65. The man was in HMP Norwich from January 2010 until his death in March 2011. From the time of his reception into Norwich, he suffered from a number of ongoing illnesses and had previously been diagnosed with cancer. Following biopsies taken during an admission to hospital, he was diagnosed with cancer of the rectum in June 2010. The condition was too advanced to be treated with chemotherapy or radiotherapy, and so palliative care was given.
66. The medical care that the man received, including his diagnosis, treatment, medical appointments and pain relief, was appropriate. There was input from palliative care specialists, and the Liverpool Care Pathway was used in the final stage of his life.
67. There was little clarity around the steps that had been taken, if any, to consider the appropriateness of compassionate release. Accordingly, a recommendation is made in this regard, as well as recommendations about the out of hours prescriptions service and the provision for end of life care.
68. The clinical reviewer makes a number of further recommendations, which are commended to the Governor and Head of Healthcare.

## RECOMMENDATIONS

1. The Head of Healthcare should ensure that out of hours prescriptions can be obtained when needed.

*The recommendation was accepted. A pharmacy on-site can be accessed in the event of emergency medication being required. Emergency stock is also held in reception, which is staffed 24 hours a day, 7 days a week.*

2. The Governor should ensure that compassionate release is considered on each occasion when it might be appropriate, and that details of the considerations are noted in both medical and prison records.

*The recommendation was accepted. The Gold Standard Framework (GSF) has been set up in conjunction with the prison and healthcare to look at the needs of prisoners requiring end of life care. Consideration for compassionate release is now part of that process, and all relevant information will be recorded on GSF documents.*

3. The Governor and Head of Healthcare should ensure that the provisions of "The Route to Success in End of Life Care" have been implemented successfully.

*The recommendation was accepted. Staff have been trained in end of life care and the GSF, and there are close links with the palliative care unit.*

4. The Head of Healthcare should ensure that the mental health needs of older prisoners at Norwich are identified and that an appropriate service is developed to meet these needs.

*The recommendation was accepted. A nurse is now designated to L wing and the inpatients unit. There are also nurses in every area across the site and meaningful daycare activities will commence in January 2012.*