Investigation into the circumstances surrounding the death of a man, a prisoner at HMP Leicester in April 2011

Report by the Prisons and Probation Ombudsman for England and Wales

May 2012

This is the report of an investigation into the death of a man, a prisoner at HMP Leicester. He was found hanging in his cell in April 2011. Resuscitation attempts were made by staff but unfortunately they were unsuccessful and he was later pronounced dead by paramedics. We offer our sincere condolences to his family and friends and to all those who have been affected by his death.

The investigation was carried out by one of our Senior Investigator. A Clinical Reviewer on behalf of Leicester City Primary Care Trust carried out a review of the man's clinical care while in custody. I apologise for the slight delay in the report.

I am grateful to the Governor of Leicester and her staff for their co-operation.

The man had arrived at Leicester on 10 December after being remanded into custody. This was his first time in prison, but he appeared to settle into the prison regime, and staff said that he gave them no cause for concern. The investigation has concluded that his death was not foreseeable, and the prison's response on 6 April was generally appropriate. Nonetheless, certain lessons should still be drawn from this tragic case. To this end, we make recommendations on improvements to first aid and resuscitation arrangements, on ensuring privacy screens do not unnecessarily impinge on safe supervision and on enhancing communications in emergencies.

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Prisons and Probation Ombudsman **May 2012**

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SUMMARY

1. The man had been on remand at Leicester since December 2010 on charges of a sexual nature, and was due to appear in court in April 2011.

2. On the day of his death, he declined to go to the gym, and staff said that while this was unusual for him, he did not give the impression that he was feeling any different to normal.

3. Later that evening while staff were unlocking cells for prisoners who were returning from the gym, they were alerted by another prisoner to a problem at the man's cell. When the officer arrived at the cell he saw him hanging by a ligature made of bed sheets at the back of the cell.

4. With the assistance of the prisoner who had raised the alarm the officer released him from the window and laid him onto the floor. Cardio pulmonary resuscitation was commenced, and continued until the arrival of paramedics who continued to treat him. However, despite their best efforts he did not respond to treatment and was pronounced dead at 7.13pm.

5. We make three recommendations relating to first aid, one regarding privacy curtains and one where consideration should be given to moving a prisoner out of his cell, should he require resuscitation as a result of the investigation.

THE INVESTIGATION PROCESS

6. The investigation into the man's death was opened on 14 April when our senior investigator visited HMP Leicester. The investigator met with two Governors. She met the family liaison officer who liaised with the man's family and was taken to the cell where he had been living. The investigator was also provided with copies of the man's prison and medical records.

7. Notices were issued and displayed around the prison, informing both staff and prisoners of the investigation. The notices asked anyone with information relating to the death to contact the investigator. One response was received from a prisoner in response to the notices. However, the prisoner informed the investigator via prison staff that he had changed his mind, and was therefore not spoken to as part of the investigation.

8. The investigator attended the prison on 6 June in order to conduct interviews with staff that had been involved with or knew the man. On completion of interviews the investigator provided feedback on her findings to the prison both verbally and in writing.

9. We apologise for the delay in providing this report. This was due to the late allocation of the clinical reviewer and the ill health of the investigator.

10. A clinical review was commissioned by NHS Leicestershire and Rutland and a reviewer kindly completed this on their behalf.

11. A family liaison officer working for the PPO contacted the man's family by telephone on 3 May to discuss the purpose and scope of the investigation and to provide them with the opportunity to raise any questions or concerns they may have about his death. The family did not raise any concerns or ask any questions about his time in custody. A copy of this report will be translated and made available to the family. The investigator wrote to the Coroner to inform them of the investigation and to request a copy of the post mortem report.

12. The report was issued in draft to the man's family and having considered the findings of the investigation they raised some concerns. In their response, they said the most significant concern was that he was found in his cell by a prisoner they believed had been bullying him. There was no evidence found within the investigation to support an allegation of bullying by another prisoner and we are unable to comment further. The family were also very concerned that the prison officer's mouthpiece had deteriorated and this had caused a delay in administering medical aid. This concern is addressed at paragraph 36 of this report and is included as a recommendation

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HMP LEICESTER

13. HMP Leicester is a Victorian prison situated in a commercial and residential district about half a mile from Leicester city centre. It was built in 1825 and further construction took place in 1874 and more recently in 1990 a new visits and administration block was built. It operates as a local prison for adult males. The main living block is a long rectangular cell block with four landings which has a capacity of 392.

14. HM Chief Inspector of Prisons last inspected Leicester in October 2010. This inspection was a follow up to the previous inspection of June 2008. They said:

> '… HMP Leicester is a small, crowded, city-centre local prison with a transient and needy population. On our previous visit, we detected signs that the prison was beginning to rise to these challenges but said that there was much more to do. On our return, for this unannounced follow-up inspection, we were pleased to find that many of our recommendations had been implemented and there had been significant improvement in a number of areas.
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> Leicester remained a reasonably safe prison. Early days in custody were managed satisfactorily, a new violence reduction strategy was now in place and suicide and self-harm prevention arrangements were adequate. Security was proportionate, use of force was not excessive and there had been improvements in both the environment and management of the segregation unit.
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> The Victorian prison environment remained worn and cramped, despite efforts to maintain decorative and cleanliness standards. Access to showers and phones was limited. Staff prisoner relationships were generally positive, supported by an array of consultative arrangements and an improving personal officer scheme. Diversity was generally well managed, with improvements noted in the management of race relations and support for foreign nationals. Faith provision was excellent.
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> Time out of cell had improved and had been accompanied by an increase in purposeful activity, although clashes with other aspects of the prison regime meant that these opportunities were not maximised. Few prisoners were unemployed but the range and quality of activities was limited. Education had improved. Access to the library and PE was good, but the outside sports area had been closed for some time …'

Independent Monitoring Board (IMB)

15. The IMB is a group of local volunteers who independently monitor and report on the prison. In their most recent annual report, dated January 2009 to February 2010 they comment on the following in areas which are relevant to the man:

- '… BME and Foreign Nationals continue to make up a significant proportion of the population with 111 BME prisoners (33%) of which 49 are Foreign Nationals (14.58%) being detained at the end of the reporting year. There are three overstayers being held on behalf of the UKBA.

- The Board is pleased to note that, since our last report, International Phone cards are being issued to those who do not have visitors.

- Weekly surgeries have been held with UKBA representatives and these appear to have been well received ...'

16. BME is an abbreviation for black and minority ethnic group prisoners.

Vulnerable Prisoner Unit (VPU)

- Purposeful activity, exercise and daily association have been increased on this unit, and wherever possible, brought in line with the rest of the prison.

- L&S classes have been moved to a more suitable location, away from interruptions.

- Communal dining still only occurs twice a week.

- Laundry facilities have been installed for prisoners use.

17. Vulnerable prisoners are those that are seen to be at potential risk due to the nature of their crimes, or due to other factors within the prison such as debt. These prisoners can be segregated at either their own request or for their own safety, by prison staff.

KEY FINDINGS

18. The man was remanded to HMP Leicester in December 2010. This was his first time in prison and on reception, he made an application to be located on the vulnerable persons unit, due to the nature of his alleged offences. He wrote in his application "due to the nature of my offence I feel I need protection." During the reception process it was recorded that the man 's visa to remain in the country had expired. These details were passed to the UK Border Agency, and it is likely that he would have been deported upon his release from custody.

19. As part of the normal reception procedures an initial healthscreen was completed by nursing staff and a cell sharing risk assessment (CSRA) by reception staff. (A healthscreen is a full medical examination by a qualified nurse and a CSRA indicates if there are any risks associated with sharing with another prisoner.) Both indicated that the man had no suicidal thoughts when he was asked.

20. The nurse who completed the initial health screen recorded that he had no previous mental health problems nor had he been treated for any psychiatric problems. The nurse recorded that if he was required to do so, the man was fit to attend work and he was subsequently transferred to the vulnerable persons (VP) unit.

21. Once on the unit he was given a double cell, which he shared with another prisoner. As a prisoner on the VP unit, he had the opportunity to speak to healthcare staff on the unit on a regular basis, but he did not raise any concerns.

22. The man appeared at a local magistrates' court on 17 December, 30 December, and 21 January 2011 and was remanded back to Leicester on each appearance. In addition to the more serious charges, he appeared at court on 10 February, for driving offences for which he was sentenced to one day in custody. Due to the period that he had already spent on remand this was considered to have been served and he again returned to Leicester as a remand prisoner.

23. Staff and records indicate that on 6 April the man spoke to his girlfriend on the telephone. He asked her to keep the sim card on which he made the call and intimated that it may be needed in court. He was also upset when someone he was asking to visit him refused. Police have considered the telephone call and interviewed his girlfriend but could find no substantive reasons to link this to his actions.

24. The investigator spoke to an Officer who was on duty on the VPU on 6 April. The Officer told the investigator that he was on duty at around 5.00pm and there were 24 prisoners on the wing. He said that at this time he was the only officer on duty. The Officer said 15 prisoners went to the gymnasium at around 5.00pm, which left nine on the landing. The man had decided not to go to the gymnasium although he usually attended, it is not known why he

chose not to go. During the investigation staff told the investigator that the man would normally go to the gym, but he rarely took part in activities when he attended.

25. The Officer explained that the vulnerable prisoner unit was “in patrol state” at this time, which means that all prisoners were in their cells and the doors were locked because he was the only officer on the wing. He said that he then went to collect the evening meal for the prisoners. Once the meals had been collected, the Officer with the assistance of some prisoners, served the meals to those that had not attended the gymnasium. The Officer told the investigator that he recalled the man collecting his meal, and he appeared to be fine, and he had no cause for concern. Meals for those prisoners that had gone to the gymnasium would be saved and provided to them on their return to the unit.

26. The Officer said that he started to unlock the cell doors for the prisoners returning from the gym at around 7.00pm. He opened the man’s cell door, looked inside and saw the privacy curtain around the toilet, which was situated at the far right of the cell. The curtains drop from the cell ceiling to the floor around the toilet area and in front of the window. The curtain covered the entire cell window and around the toilet area, in order to give prisoners dignity.

27. The Officer said that he assumed that the man was using the toilet and carried on along the wing to open the next cell. As he continued along the landing, he said that he noticed another prisoner enter the man’s cell, before coming straight back out and calling to him, in what he described as ‘a panicked state.’

28. The officer told the investigator that his first thought was that there was a fight happening in the man’s cell and he shouted for staff to assist him before he reached the cell. A member of staff who was in the office and heard his shout for assistance, sounded the general alarm, to inform staff of an incident. An entry was made in the control room log at 7.13pm, when the general alarm was sounded. The Officer made his way to the cell and said that it was about eight strides to the cell and he was there in ‘no time.’

29. As he arrived at the cell, the Officer said that the prisoner who had called to him, was trying to pull him into the cell, but he had to prove the cell door before entering. (For safety a deadbolt is used when staff have to go into a cell, this is referred to as ‘proving the door’. It stops the cell door being locked on the member of staff.) The prisoner then went into the cell and pulled the privacy curtain back to reveal the man hanging from the window bars by a ligature, made of bed sheets.

30. The officer and the prisoner were the only people in the cell, and he asked the prisoner to hold the man’s body up so that he could use his cut down tool to cut the ligature from the window bars. (Cut-down tools are used to cut ligatures. All staff in closed and semi-open prisons who have contact with

prisoners must be provided with and carry, when on duty, their own personal issue tool.)

31. Once the ligature was released, the Officer and the prisoner laid the man on the cell floor, although space was limited. The Officer removed the remainder of the ligature from around the man's neck. When spoken to by the investigator, the Officer said that he was warm to the touch, but his body was very limp. At this stage the officer said that he noticed other staff in the cell and also that the prisoner assisting him had gone. Staff said that the prisoner was subsequently offered support by Listeners and staff. He subsequently chose not come forward to speak to the investigator.

32. A Senior Officer (SO) and an Officer were on the level 2 landing when they heard the general alarm sound in the vulnerable prisoners unit. Both said that they were about 10 metres away from the gate and thought that the alarm was indicating a fight on the landing. When they arrived they said that there were a lot of prisoners milling about on the landing as they had just come back from the gymnasium. The SO said he noticed the prisoner who had been in the man's cell standing on the landing, looking shocked. The SO asked other staff to take the prisoners back into their cells and carried on towards the man's cell. He said that at this time he still thought it was a fight.

33. When he arrived at the man's cell with the Officer. The SO saw that the Officer who was on duty on the VPU had just laid him on the cell floor and removed the ligature from his neck. The Officer said there was very little room in the cell so they moved him into a space, before checking for a pulse. The Officer said that there was no pulse and he was not breathing so he began chest compressions. Whilst he was carrying these out he heard a code blue emergency call over the radio. A code blue emergency call is made when a prisoner is not breathing and is unconscious and alerts healthcare staff to bring the emergency bag containing resuscitation equipment.

34. When the alarm sounded a Nurse was the emergency response nurse (radio call sign hotel 4.) The Nurse said that she was the nurse who would respond to any alarms within the prison. At the time of the alarm she was in the segregation annex dispensing medication. When she heard the alarm she immediately ran to the treatment room to secure the medication, before speaking to an officer who told her that a prisoner had been found hanging. She immediately returned to the treatment room to collect the emergency medical bag and made her way to the VPU. On her way there she said that she heard the code blue emergency call over the radio.

35. Another nurse had just finished her duties in the reception area when she heard the alarm and a few minutes later the code blue emergency call. She said that she knew that the first nurse was on her own so she made her way to the VPU to assist her.

36. The first nurse said that when she got to the cell she saw the SO and another Officer carrying out chest compressions on the man. She said that as she

was opening the emergency bag, the second nurse who made her way to the VPU to assist with the man and the doctor came into the cell. The first nurse asked the officers if they wanted her to take over and they said they were happy to continue. The other nurse said that when she went into the cell she saw the man lying on the floor but at that stage she did not know he had hung himself. The SO said that he was trying to put a resuscitation aid (a small device with a protective plastic sheet and a hole in the middle to blow through) over his mouth so he could give him some rescue breaths, but he needed to clear the man's airway first. He opened the packet for the aid but when he removed it from the packet he found that it was damaged and unusable.

37. The second nurse took over and inserted a suction catheter into the man's mouth to clear his airway and then attached an oxygen mask. (A suction catheter is an instrument which removes any debris from the mouth.) She told my investigator that with any type of code blue situation the first thing she would do is to give the patient oxygen. The officers continued rotating with compressions at 30 compressions to two breaths and the nurse and the doctor carried out observations on the man. There were no signs of life.

38. The nurse then changed the constant oxygen supply to one with an ambu bag and facemask. (An ambu bag is a flexible air bag connected by rubber tubing to a face mask, which is used for artificial ventilation when a patient is not breathing.) The nurse explained that this gives a better seal around the patient's mouth. At the same time as she was doing this the nurse who respond to alarms was preparing the defibrillator for use on the man. (A defibrillator is an electrical device which when attached to a patient's chest, shocks the heart into a natural rhythm. It can only shock when natural electricity is still present in the heart. If this is not present, the defibrillator will advise to continue CPR.)

39. The nurse explained that whilst she was trying to open the defibrillator pads, to stick them onto his chest she struggled to undo the packaging. She said that the defibrillator advised staff to stand clear. However, it then advised to continue compressions. Staff said that his body was in a pool of liquid, which they believed to be urine at the time when the defibrillator was attached to him. They were concerned that if the defibrillator had advised to shock and that had been carried out, they would have been in the water too and therefore subject to danger from the electricity.

40. My investigator asked the nurse whether she was aware that there was any liquid on the floor close to the man. The nurse said that she was, but they were unable to move him out of the cell. She said that it would have been inappropriate to move him out of the cell onto the landing. She said that she felt she just had to continue with the process to try to save his life. She and the prison staff said that they did not remember anyone coming to dry up the liquid, however, the nurse said that she thought people had brought some towels.

41. Staff involved in the resuscitation attempt were asked if they had been first aid or CPR trained. Whilst the nurses were fully trained and up to date none of

the discipline staff were qualified. The nursing staff said that they had been trained in the use of the defibrillator, as was one of the discipline staff.

42. CPR continued for around 15 minutes before the arrival of emergency paramedics. At this stage the doctor and the paramedics made a decision to stop CPR and pronounced him dead at 7.37pm. Other prisoners were later informed about the death and offered the support of Listeners and all those on suicide prevention measures were reviewed. (Listeners are prisoners who are trained by the Samaritans service to provide a counselling service to other prisoners.)

Events following the man's death

43. Immediately after his death a hot debrief took place with the staff that had been involved in trying to treat him chaired by one of the Governors (A hot debrief is a meeting immediately after a serious incident or death, where all those involved are offered the support of the duty care team and are supported by managers.) The staff said that they found this meeting useful and supportive. All the staff were offered support from the duty care team.

44. As part of the prison response to his death, the man's most recent telephone calls were monitored, and a recording of these provided to the police. The police have found nothing conclusive in the telephone calls that indicates a reason for him to have taken his own life.

45. After the death the Governor of Leicester, and the family liaison officer visited the man's next of kin to break the news of his death. There was some confusion because he had only listed some friends as his next of kin. The Governor visited the house and was then told the address details of the man's girlfriend and subsequently informed her of his death. She contacted the man's family in his country and they asked the prison to make contact with other family members in this country. They were subsequently visited by the family liaison officer and all parties were kept informed of the funeral arrangements. They were offered financial assistance with his funeral.

ISSUES

Health/self harm risk

46. The Clinical Reviewer states that "There is nothing recorded in man's medical record that suggests that healthcare or other staff at HMP Leicester could or should have regarded him as being at higher risk that other prisoners of self harm or suicide". He makes two recommendations to the Governor and Head of Healthcare in his clinical review, relating to follow up appointments and clinical records. We concur with the Clinical Reviewer view in respect of the risks of self harm to the man.

Privacy curtains in cells

47. When the officer who was on duty on the VPU opened the man's cell door, he saw the privacy curtain around the toilet and assumed that he was using it. He subsequently continued unlocking other cell doors. When interviewed staff said that in their opinion they felt that if the privacy curtain did not cover the entire window, there would be less chance of a prisoner using the window as a ligature point.

48. There are inherent limitations in terms of both practicality and cost, as to the changes that can be made to the physical fabric of Victorian prisons such as Leicester. However, it would be entirely feasible to move the privacy curtain, so that it does not cover such a large area when drawn.

We therefore recommend that the Governor ensures that privacy curtains are moved so that they do not cover the whole of the window but provide a balance between personal dignity and safety.

Finding the Man – Prisoner involvement

49. The prisoner who found the man and alerted the officer who was on duty on the VPU, then assisted the Officer to get him down from the ligature point. The Officer and the prisoner had managed to get him down, remove the ligature from his neck, and move him away from the toilet area before any other staff arrived to assist.

50. Whilst it is always preferable for prisoners not to be involved with resuscitation attempts, on this occasion it was the most appropriate response. Although CPR was unsuccessful, a prompt response, such as this by anyone present might achieve a different outcome. According to staff, support and guidance was given to the prisoner.

Emergency call/Communication with healthcare

51. Although the Officer had raised the general alarm before going into the cell, it seemed to take some time to raise an emergency code blue call. Officers at the scene were aware that the man had hung himself, but when nurses arrived at the cell, they were unaware of what had happened. According to

the Nurse who went to the VPU to assist with the man, she was still unaware what had happened to the man when she started to treat him. While it would seem from the clinical review that there was unlikely to be a different outcome, staff should be given advice on how to respond to a similar incident and reminded that an emergency call with as much information as possible is given to the control room.

We therefore recommend that the Governor and Head of Healthcare should ensure that when emergency calls are made comprehensive information is passed to all staff including healthcare staff.

Response/First Aid Training

52. The Clinical Reviewer says that "The resuscitation attempt appears to have been conducted well." However, three members of staff performed CPR on the man and none of them had current first aid qualifications. Their certificates had expired some years ago. However, all staff did their best to resuscitate him and they were mainly observed by qualified healthcare staff. When the SO tried to give rescue breaths to him, he was handed a small resuscitation aid that is held on a prison officer's belt. Unfortunately when he opened it he found that it had perished and was unusable. Fortunately healthcare staff arrived at the cell at the same time and were able to attach oxygen, via a face mask.

53. The Clinical Reviewer comments on the resuscitation attempt thus:

> "The evidence suggests that the artificial respiration was carried out competently…I have recommended in a previous report that the Prison Service and Healthcare Services at HMP Leicester consider the provision of Resusci-Aid mouth protectors (or similar) for all staff, especially those who have been trained in CPR and, very importantly, training and regular updating in their use…"

54. The Clinical Reviewer makes one recommendation with which we concur and recast into two recommendations here:

The Governor and Head of Healthcare should ensure that all staff should be first aid trained and their certificates should be kept up to date.

The Head of Healthcare should ensure that all staff are provided with resusci aid mouthpieces, which are regularly replaced.

55. At the time of the emergency response, the man was lying on a wet floor. This was believed to be urine. Some staff were concerned that if the defibrillator was used they would have also been shocked because they were standing or kneeling in the liquid.

56. Staff safety is paramount and, although they were engaged in trying to save his life, it is inappropriate and dangerous to use the defibrillator to shock when this poses a potential risk to another person.

57. The Clinical Reviewer says that:

> " … if another person is in contact with the patient in such a way that an electrical connection can be made there is the possibility of the other person receiving a part of the charge from the defibrillator. He said that the amount of shock that the other person might feel would depend on the electrical resistance of that connection. In this case the electrical connection would have been via the fluid on the floor. If a member of staff had been kneeling in the fluid or had a hand in it and if a shock had been delivered that member of staff might have felt a shock but if he/she had simply been standing in the fluid it is likely that the soles of his/her shoes would have provided sufficient insulation for no shock to have been felt. Nevertheless, if a shock had been going to be delivered, it would have been prudent for all staff to have ensured the area around the man was dry ...'

58. All staff interviewed acknowledged that the space available in the cell was very limited. The Clinical Reviewer said that in a previous clinical review a prisoner was carried out of his cell and onto the landing to ensure there was enough space to treat him safely. He makes one recommendation with which we concur and slightly recast:

The Governor and Head of Healthcare should instruct staff to ensure that when a prisoner requires resuscitation he is placed in the most appropriate place available, to make the task of CPR easier, safer and therefore potentially more effective.

CONCLUSION

59. The man had been in custody at Leicester for approximately four months. He was due to stand trial for alleged sex offences on 11 April. He was also a foreign national and was aware that when he was released from prison he would be liable to be deported from the country.

60. On the 6 April he made a telephone call to his girlfriend asking her to keep the sim card on which he made the call and intimated that it may be needed in court. He was also upset when someone he was asking to visit him refused. Although it is impossible to know what impact this had on his state of mind.

61. When he was found by another prisoner, support was given to the prisoner and every effort was made to resuscitate him. Unfortunately this was unsuccessful. Although certain deficiencies were identified in the conduct of these efforts, none are considered to have affected the tragic outcome.

RECOMMENDATIONS

1. We recommend that the Governor ensures that privacy curtains are moved so that they do not cover the whole of the window to provide a balance between personal dignity and safety.

The prison has accepted this recommendation. They state, "Curtains that cover the whole window will be replaced by curtains with a transparent part at the top of the curtain or wherever possible rails adjusted to ensure that they do not cover the whole window dependent on the physical design of each cell."

2. We recommend that the Governor and Head of Healthcare should ensure that when emergency calls are made comprehensive information is passed to all staff including healthcare staff.

The prison has accepted this recommendation. They state, "The instruction regarding the protocol for calling for emergency medical assistance has been reissued and reiterated to all staff.

3. The Governor and Head of Healthcare should ensure that all staff should be First aid trained and their certificates should be kept up to date.

The prison has rejected this recommendation. They state, "It is not current Prison Service Policy to train all staff in first aid, however all operational Healthcare staff are routinely trained in Immediate Life Support (ILS) and are updated in this training annually. Other selected Prison Service staff are on a rolling programme to be trained in Immediate Life Support. Levels of qualified first aid trained staff are in line with relevant health and safety legislation, currently there are thirty six staff trained and in date which is considered reasonable, practical and proportionate to the risk.

4. The Head of Healthcare should ensure that all staff are provided with resusci aid mouthpieces, which are regularly replaced.

The prison has rejected this recommendation. They state, "It is impractical for all staff to carry resusci aid mouthpieces, however Laerdal masks for resuscitation are available in all offices and prisoner areas and resuscitation masks are a standard inclusion in all emergency "grab bags" as agreed in previous Prison and Probation recommendation.

5. The Governor and Head of Healthcare should consider whether movement of a prisoner who requires resuscitation out of his cell could be made the norm. This would reduce the risk of electrical contact being made between the patient and staff and would make the task of CPR easier and therefore potentially more effective.

The prison has rejected this recommendation. They state, "It is not possible to make this procedure the norm, due to restricted spaces on the majority of landings and is not always safe, practical or possible. Nurses use their clinical and general

judgement to determine whether or not this would be advantageous in each individual situation.