Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Trevor Burchell, a prisoner at HMP/YOI Elmley, on 12 February 2022

A report by the Prisons and Probation Ombudsman

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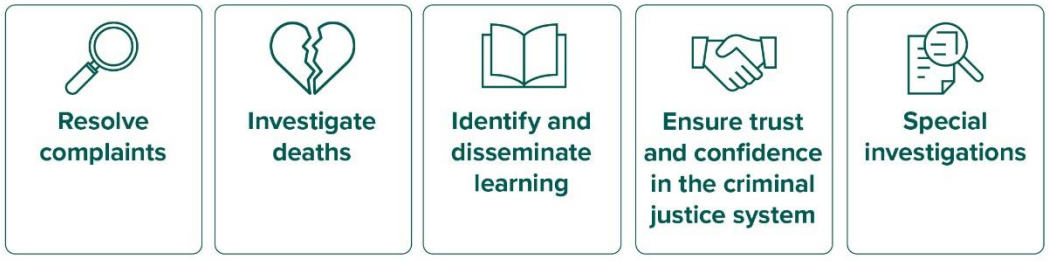
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Trevor Burchell was found hanged in his cell on 6 February 2022 at HMP Elmley. He died in hospital on 12 February. He was 56 years old. I offer my condolences to Mr Burchell's family and friends.

Mr Burchell was serving an indeterminate sentence for public protection (IPP). He was first released in February 2017, seven years and three months past his minimum tariff. He was recalled to prison five months later after he breached the conditions of his licence. Mr Burchell was then released again in November 2021, before he was recalled 12 days later.

In September 2023, we issued a learning lessons bulletin in response to the worrying increase in self-inflicted deaths of prisoners serving Imprisonment for Public Protection (IPP) sentences in 2022. We have continued to see self-inflicted deaths of IPP prisoners in 2023. Our investigations have found that IPP prisoners struggle with their uncertain status leading to feelings of hopelessness and frustration. This can cause a lack of engagement with the parole process and sentence planning and create a lack of trust in the system. Mr Burchell's story serves to illustrate these concerns.

Prison staff knew Mr Burchell well and ACCT procedures provided him with some support. The lack of multi-disciplinary attendance at case reviews meant that staff did not fully explore how Mr Burchell's recall impacted on his belief that he was being set up to fail.

The clinical reviewer found that Mr Burchell did not receive appropriate mental health support and his overall mental health care was not equivalent to what he could have expected to receive in the community.

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

Adrian Usher
Prisons and Probation Ombudsman **February 2024**

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Summary

Events

1. In March 2007, Mr Trevor Burchell was given an indeterminate sentence for public protection (IPP) with a minimum time to serve of 2 years, 7 months and 16 days, for wounding with intent. He absconded from prison in 2012 and 2013. Mr Burchell was released on licence from HMP Elmley in February 2017, but was recalled five months later. He was then released again on 19 November 2021, and recalled to Elmley on 1 December.

2. Mr Burchell had a history of poor mental health and self-harm. He refused to take his medication and said that he understood the impact on his physical and mental health.

3. Mr Burchell was managed under Prison Service suicide and self-harm monitoring procedures (known as ACCT) from 20 December, after he told his prison offender manager that he would leave prison in a box. Mr Burchell said he had no hope for the future and had stopped taking his medication to help him die.

4. At 5.22pm on 6 February 2022, Mr Burchell had placed his mattress against his cell door and turned his bedframe upright. Prison officers used an anti-barricade key (used to unlock a door outwards) to enter Mr Burchell's cell and found him ligatured from the bedframe.

5. Paramedics took Mr Burchell to hospital, but he did not recover. Mr Burchell died at 8.05am on 12 February.

Findings

6. Mr Burchell had a number of risk factors which indicated that he was at risk of suicide and self-harm. He felt hopeless about his recall to prison and that he would continue to fail when he was released into the community because of the trauma he had suffered in the past.

7. ACCT procedures provided some support to Mr Burchell. Prison staff were aware of his previous history and how it affected his ability to cope. Case reviews were not consistently multi-disciplinary which meant staff missed the opportunity to explore how the wider issues associated with his release and recall impacted on his low mood.

8. Mr Burchell had complex mental health needs. He had raised concerns that he was not receiving the support he needed and was non-compliant with his antidepressant medication. The mental health team did not complete a mental health assessment after his recall to Elmley or after he threatened to attempt suicide and it was unclear why he did not meet their criteria for support.

9. The clinical reviewer concluded that Mr Burchell's mental health care was not equivalent to what he could have expected to receive in the community.

The Investigation Process

10. On 14 February 2022, HMPPS notified us of Mr Burchell's death. The investigator issued notices to staff and prisoners at HMP Elmley informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

11. The investigator visited Elmley on 24 February. She obtained copies of relevant extracts from Mr Burchell's prison and medical records.

12. NHS England commissioned a clinical reviewer to review Mr Burchell's clinical care at the prison.

13. The investigator interviewed six members of staff at Elmley. She and the clinical reviewer jointly interviewed clinical staff.

14. The investigation was delayed while we waited for the clinical review report.

15. We informed HM Coroner for Kent of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

16. We wrote to Mr Burchell's sister to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not have any questions but asked for a copy of the report.

17. Mr Burchell's sister received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.

18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Elmley

19. HMP Elmley holds up to 1,252 men, remanded and sentenced, in six houseblocks with a mixture of single, double and triple cells. Integrated Care 24 Ltd provides 24-hour primary healthcare services, with input from Minster Medical Group. Oxleas NHS Foundation Trust provides mental health services.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Elmley was in February and March 2022. Inspectors reported that there had been four self-inflicted deaths since the last inspection. The prison had begun implementing PPO recommendations, but implementation was not monitored over time to ensure on-going compliance. Reported self-harm was lower than in most comparable prisons but had increased since the last inspection. Prisoners supported through ACCT case management were generally positive about the care they received, although there were some weaknesses in the process itself.

21. In February 2023, an independent review of progress took place. The report said that Elmley faced substantial staff shortages, but leaders were focused on how to make improvements with the resources they had and were delivering more than many prisons with a similar or better staffing position.

Independent Monitoring Board

22. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to November 2021, the IMB reported that there should have been greater, more formal analysis of self-harm. ACCT documents were valuable for recording such events and their possible triggers, but the underlying causes seemed never to be identified in relation to the prison environment.

Previous deaths at HMP Elmley

23. Mr Burchell was the nineteenth prisoner to die at Elmley since February 2019. Of the previous deaths, three were self-inflicted, 13 were from natural causes and two were drug related. There have been two natural cause deaths since. There were no similarities with the previous investigations.

Assessment, Care in Custody and Teamwork

24. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be

irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.

25. As part of the process, a care plan (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the care plan have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Parole Board

26. The Parole Board for England and Wales is an independent public body. Its role is to make risk assessments about prisoners to decide whether they can safely be released into the community once they have served the minimum term imposed by the courts.

Indeterminate sentence for Public Protection (IPP)

27. IPP sentences were abolished in 2012. They were intended to protect the public against offenders whose crimes were not serious enough to merit a normal life sentence, but who could only be released once they had served their minimum tariff and had demonstrated to the satisfaction of the Parole Board that they had sufficiently reduced their risk. There are currently about 3,000 IPP prisoners, of which half have never been released.

28. Since June 2022, all Parole Board recommendations for the transfer to open conditions and release of IPP prisoners must be approved by the Secretary of State for Justice.

Key Events

29. On 20 March 2007, Mr Trevor Burchell received an indeterminate sentence for public protection (IPP) for wounding with intent. He was given a tariff of 2 years, 7 months and 16 days (the minimum he would have to spend in prison before he could be released) and was sent to HMP Swaleside. Mr Burchell had a history of offending and had been in prison before.

30. In June 2012, Mr Burchell absconded from HMP Blantyre House and in June 2013, from HMP Stamford Hill. He was released from HMP Elmley on 22 February 2017 and recalled on 17 July after he failed to comply with the conditions of his licence.

31. Mr Burchell had been managed under Prison Service suicide and self-harm monitoring procedures (known as ACCT) on 18 occasions since June 2013, after he reported suicidal thoughts caused by a low mood.

32. The prison's mental health team saw Mr Burchell throughout his time in prison and before his release on licence. Mr Burchell said that he had suffered both physical and sexual abuse as a child. In 2015, Mr Burchell was diagnosed with post-traumatic stress disorder (PTSD - an anxiety disorder caused by a very stressful, frightening or distressing event).

33. Mr Burchell completed psychological therapy but his engagement was often inconsistent. In September 2021, he was referred to the prison psychologist, but he was not considered suitable for further psychological intervention. A prison psychologist noted that Mr Burchell had completed Step 4 therapy (a therapeutic process to increase a patient's understanding of their problems and how these influence relationships) and no appropriate treatment was available for him.

34. Mr Burchell had regular appointments with his Prison Offender Manager (POM) and Community Offender Manager (COM) to prepare for his release. He also received support from The Forward Trust (a charity which helps people with drug and alcohol dependence).

35. On 13 September, The Parole Board directed Mr Burchell's release on licence to Fleming House Approved Premises (AP). The panel noted Mr Burchell's concerns that he would be associating with sex offenders, specifically at mealtimes, and the trauma he had suffered as a child. Mr Burchell would be provided with his own room and would not be expected to eat with other residents.

36. On 19 November, Mr Burchell was released from Elmley. Shortly after he arrived at Fleming House, Mr Burchell threatened another resident with violence, as he was aware the resident had committed a sexually related offence. AP staff issued Mr Burchell with a warning for his behaviour. Mr Burchell's behaviour did not improve and he continued to display threatening and abusive behaviour towards other residents. Mr Burchell refused to engage with AP staff, demanded to be returned to prison and threatened to harm staff. He also used homophobic language towards another resident and told staff that he did not want to live with sex offenders. AP staff noted Mr Burchell's index offence of wounding with intent and that his behaviour indicated that his risk of committing a violent offence had increased.

37. Mr Burchell's COM agreed with AP staff that Mr Burchell's behaviour could not be managed in the community and there were no suitable alternatives to recall. Mr Burchell had breached the conditions of his licence. The COM told the investigator that withdrawing Mr Burchell's place at the AP meant that he was homeless through the loss of his accommodation and there was no other suitable address available to him.

38. On 1 December, Mr Burchell was recalled to prison and he was returned to Elmley.

HMP Elmley

39. During an initial health screen, a nurse identified that Mr Burchell had a history of angina, type 2 diabetes and high cholesterol. She noted that Mr Burchell had been prescribed metformin (to regulate blood sugars) atorvastatin (to lower cholesterol) bisoprolol (for high blood pressure) and escitalopram (antidepressant). Mr Burchell refused to take his medication. He denied any thoughts of suicide and self-harm. She referred Mr Burchell to the mental health team.

40. Prison staff completed a cell sharing risk assessment (CSRA) and recorded that Mr Burchell was high risk because of his mental health. Mr Burchell was allocated a single cell on Houseblock 1, the induction wing. Mr Burchell refused to engage with the prison's resettlement team and staff noted that he refused to take responsibility for his recall to prison.

41. On 10 December, a nurse spoke to Mr Burchell because he was still refusing to take his medication. Mr Burchell said that he felt like he had given up but did not want to hurt himself and denied any thoughts of suicide and self-harm. He understood the effects of not taking his medication on his physical and mental health. The nurse made another referral to the mental health team. That day, Mr Burchell refused to attend a GP appointment.

42. On 13 December, mental health staff discussed Mr Burchell at a multi-disciplinary team meeting and decided he did not need further input or support, but they did not record the reasons for this. A mental health nurse saw Mr Burchell on 16 December. She did not record any details about Mr Burchell's presentation in his clinical record.

43. On 20 December, a POM, began ACCT monitoring after Mr Burchell told her that the only way out of prison was in a body bag and the only option left was to attempt suicide.

44. Mr Burchell told Officer A at his ACCT assessment that he had no hope for the future and had stopped taking his medication on 13 December to help him die. Mr Burchell said that he wanted a transfer to another prison because he was unhappy that he was released to an AP in Kent.

45. A Senior Officer (SO) was appointed as ACCT case manager and held a case review on 21 December with Mr Burchell, Officer A and the prison chaplain. Mr Burchell said that he was destined to fail at Fleming House because he had suffered sexual abuse as a child and he did not want to live with sex offenders. The SO added four actions to Mr Burchell's caremap (designed to identify the main areas of concern and the actions required to reduce risk): that he should see the

psychology team, continue to access the wing regime, engage with the Forward Trust and continue to seek support from his family. She assessed Mr Burchell's risk of suicide and self-harm as medium and decided that he should have two quality conversations with staff during the day and he should be monitored five times during the night. She decided that Mr Burchell would remain on Houseblock 1 because staff knew him well and were able to provide support.

46. On 28 December, Mr Burchell refused to attend a case review with the SO. He denied any thoughts of suicide and self-harm. Because Mr Burchell would not engage with the case review, she increased his observations to one every hour.

47. During a case review on 29 December, Mr Burchell said that he could not cope at Fleming House and was suffering from PTSD. A mental health nurse told the review she would refer Mr Burchell to the Bradley Therapy Service (psychological therapy services for prisoners in Kent) for additional support. Mr Burchell said he was still refusing to take his medication because he felt that it did not work. That day, Mr Burchell did not attend his appointment with a mental health nurse.

48. On 5 January 2022, a prison psychologist noted that she had not accepted Mr Burchell's referral because there was no change in his presentation since the previous referral in September 2021. She said that Mr Burchell's previous engagement with psychology was sporadic and there was no appropriate treatment available for him.

49. During a mental health team referral meeting on 6 January, a nurse noted that the mental health nurse had continued to see Mr Burchell despite him being previously discharged. The mental health team decided that Mr Burchell did not need any further input and discharged him from their care again.

50. On 9 January, the SO held an interim case review because wing staff were concerned that Mr Burchell's mood had deteriorated. Mr Burchell was sitting on his cell floor, visibly distressed. He was worried that staff were going to hurt him but said that nothing had happened. Mr Burchell said he was not taking his medication and denied any thoughts of suicide and self-harm. The SO told Mr Burchell that she was concerned for his safety. Mr Burchell refused to move to a safer cell (a cell designed with fewer known ligature points) and said that he wanted to remain in his cell where he felt safe. She noted that Mr Burchell had not recently self-harmed, but she increased Mr Burchell's observations to two every hour and made wing staff aware of the change.

51. On 18 January, Mr Burchell refused to attend a case review and asked to see the mental health team. A nurse saw Mr Burchell in his cell and noted that he was distressed and crying. Mr Burchell said that he felt that his mental health was deteriorating and nobody was helping him. On 19 January, Mr Burchell attended a case review with a SO and the nurse. Mr Burchell said he felt better and wanted to move to a prison outside of Kent for a fresh start and would discuss this with his prison offender manager. The SO reduced Mr Burchell's observations to one every hour. A GP appointment was made for 25 January to discuss his medication.

52. During the appointment on 25 January, a GP at the prison advised Mr Burchell of the importance of taking his medication. Mr Burchell refused to discuss taking an alternative antidepressant medication and said that he would continue to refuse his

prescribed medication. The GP discussed the impact this could have on his blood pressure. Mr Burchell became angry and left the appointment. The GP made a referral to the Cardiology Department and arranged an electrocardiogram (ECG- to diagnose and monitor conditions affecting the heart). There is no evidence that Mr Burchell had an ECG before he died.

53. That day, the prison psychologist told the mental health team manager that she would provide information about Mr Burchell to the safety intervention meeting (SIM - a weekly multi-disciplinary meeting to discuss prisoners who are at risk). She attended the SIM on 2 February. There is no evidence that the meeting discussed Mr Burchell.

54. On 26 January, Mr Burchell refused to attend a case review. An officer spoke to Mr Burchell at his cell. Mr Burchell said that staff had stolen money from him in 2017, and that staff had assaulted him, but he did not say when this had happened. Mr Burchell felt that staff were not listening to him. Staff did not record taking any action to investigate Mr Burchell's claims. He told the officer that he had not eaten that day but agreed to have a drink and two breakfast packs. That day, Mr Burchell told staff that he had experienced a seizure. A nurse completed an assessment and concluded that Mr Burchell was physically stable, and his issues were behavioural, rather than clinical.

55. On 28 January, Mr Burchell asked the observation, classification and allocation (OCA) department for information about a transfer to HMP Warren Hill, HMP The Mount or HMP Coldingley. They advised Mr Burchell that, as he had been recalled to prison in December 2021, he would need a recall security category review before he was eligible for a transfer and that he should discuss this with his POM.

56. On 31 January, a SO held a case review with Mr Burchell. Mr Burchell said that he felt better and denied any thoughts of suicide and self-harm. She decided to continue ACCT monitoring and reduced Mr Burchell's observations to two conversations a day and hourly observations during the night. The next case review would take place on 7 February.

57. That day, Mr Burchell refused to attend an assessment with the prison psychologist but agreed to attend on 1 February. She advised Mr Burchell about using mindfulness to manage his emotions. She agreed to see him again the following week to offer support with relaxation techniques to manage his anxiety and stress. She noted that she would also discuss Mr Burchell in the SIM.

58. Over the next few days, prison staff recorded in Mr Burchell's ACCT record that he was not fully engaging with the wing regime and preferred to stay in his cell. Mr Burchell collected his meals but continued to refuse his medication. Mr Burchell did not make any telephone calls or receive any visits between 31 January and 6 February.

Events of 6 February

59. At 10.45am on 6 February, an officer noted in Mr Burchell's ACCT record that he had declined his medication and lunch. Mr Burchell was crying and said that he wished everyone would leave him alone. The officer checked Mr Burchell again at 3.00pm and noted that he was lying in bed and did not express any concerns.

During an observation at 4.30pm, another officer noted that Mr Burchell was angry that staff kept coming to his cell. He told her that he intended to take the next member of staff he saw hostage. She made an entry in Mr Burchell's NOMIS (electronic prison record) and in the wing observation book.

60. At 5.14pm, Mr Burchell rang his cell bell and Officer B responded. As the night light was not working, the officer used his torch to look into the cell. Mr Burchell was pacing around his cell and had turned his bedframe upright. He refused to engage in conversation. At 5.20pm, the officer went to the wing office and spoke to Officer C about Mr Burchell. Officer C knew Mr Burchell well and said he would try and talk to him.

61. Both officers returned to Mr Burchell's cell at 5.22pm, and saw that Mr Burchell was sitting on the cell floor behind the bed and the cell door was obscured by the mattress. Officer C said that he tried to persuade him to remove the mattress. Mr Burchell refused to remove the mattress and the officers decided they would enter Mr Burchell's cell. At 5.24pm, both officers left Mr Burchell's cell and returned with the anti-barricade key (used to unlock a door outwards).

62. At 5.26pm, both officers entered Mr Burchell's cell and found Mr Burchell ligatured from the bedframe. Officer C removed the ligature and Officer B immediately radioed an emergency code blue (indicating that a prisoner is unconscious or is having difficulty breathing). Both officers then started cardiopulmonary resuscitation (CPR). A nurse arrived at 5.33pm and assisted with CPR.

63. At 5.51pm, paramedics arrived and took control of Mr Burchell's care. He was taken to hospital at 6.46pm. Two officers accompanied Mr Burchell and did not use restraints.

64. Mr Burchell's condition deteriorated and he was placed on life support. On 12 February, hospital doctors decided to remove him from life support and at 8.05am, it was confirmed that Mr Burchell had died.

Contact with Mr Burchell's family

65. On 6 February, the prison appointed a family liaison officer. She identified Mr Burchell's sister as his next of kin and told her that Mr Burchell was in hospital. Mr Burchell's sister visited him in hospital and was present when he died on 12 February.

66. The prison contributed towards the cost of Mr Burchell's funeral in line with national policy.

Support for prisoners and staff

67. After Mr Burchell's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

68. The prison posted notices informing other prisoners of Mr Burchell's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Burchell's death.

Post-mortem report

69. The pathologist gave Mr Burchell's cause of death as a fatal pressure on the neck. A toxicological analysis did not detect any illicit substances in Mr Burchell's blood.

Inquest

70. At an inquest on 16 April 2024 the Coroner concluded that Mr Burchell died as a result of a self-applied ligature, but the evidence was insufficient to determine whether he intended to end his life.

Findings

Assessment of Mr Burchell's risk

71. Mr Burchell had a number of risk factors which indicated that he was at high risk of suicide and self-harm. He had a long history of making threats to harm himself and his mental health was poor and deteriorating by the day. It is clear from this investigation that Mr Burchell was left feeling hopeless by his recall to prison. Mr Burchell believed he would continue to fail when he was in the community because his PTSD meant he was unable to control his emotions, resulting in violent behaviour towards those he felt aggrieved by.

72. We consider that ACCT procedures provided some support to Mr Burchell. Staff held regular case reviews, although these were not consistently multi-disciplinary. They added actions to Mr Burchell's caremap which reflected the issues with his medication and his engagement with the psychologist. Staff were aware of his previous history and how this impacted on his ability to cope. It is evident from the decision of the ACCT case manager to keep him on houseblock 1, that wing staff had tried hard to offer Mr Burchell consistent support.

Mental health

73. The clinical reviewer found that Mr Burchell's mental health care was not equivalent to what he could have expected to receive in the community. Mr Burchell had complex mental health needs and had raised concerns that he was not receiving the support he needed. Prior to his release on 19 November 2021, Mr Burchell received regular support from the mental health team.

74. The clinical reviewer found that there was no evidence that mental health staff completed a formal assessment when Mr Burchell returned to prison on 1 December, or when he threatened to attempt suicide. There was no clear rationale for their decision that he did not meet their criteria for support. Mr Burchell demonstrated clear issues of concern, such as his non-compliance with his antidepressant medication and his previous diagnosis of PTSD. Mental health attendance at case reviews was inconsistent and their input was limited to making a referral to the psychologist.

75. The clinical reviewer has made some recommendations about mental health assessments, record keeping and training, which we do not repeat in this report, but which the Head of Healthcare will wish to address.

Governor to Note

Events of 6 February

76. During the evening of 6 February, officers became concerned about Mr Burchell's behaviour after he barricaded his cell, turned his bed frame on end and would not engage with staff. Staff were right to act on their concerns and decide they needed to enter the cell. In the two minutes they were gone, Mr Burchell hanged himself. Clearly the two officers had assessed Mr Burchell as at heightened risk, but had not

seen him with a ligature, or anticipated the speed with which he would act. The Governor will wish to consider the sequence of events and whether there is any learning for the prison.

Case reviews

77. PSI 64/2011 requires that healthcare attend the first review and that a case manager must be appointed at this time. It also states that ACCT case reviews must be multi-disciplinary where possible because this is the most effective way to assess and manage risk, and that the ACCT process will operate more effectively if there is continuity in the attendance of staff.

78. Mr Burchell was a licence recall and his IPP sentence meant he would remain in prison for the foreseeable future. Mr Burchell said that he was destined to fail in the community and he felt that the system had let him down. We note that a SO was appointed as Mr Burchell's case manager and she provided him with good, consistent support. Healthcare staff did not attend the first case review.

79. Mr Burchell's case reviews were not consistently multi-disciplinary and his prison offender manager did not attend any case reviews. This was a missed opportunity to explore how his IPP sentence impacted on his feelings of frustration that he was destined to fail in the community and that he was trapped in an cycle of release and recall.

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