INVESTIGATION REPORT
INTO THE CIRCUMSTANCES
SURROUNDING THE DEATH OF

MR JONATHAN STEWART
AGED 38
AT MAGHABERRY PRISON
ON 17 MAY 2017

The role of the Prisoner Ombudsman

The Prisoner Ombudsman for Northern Ireland is responsible for providing an independent and impartial investigation into deaths in prison custody in Northern Ireland. This includes the deaths of people shortly after their release from prison and incidents of serious self-harm.

The purpose of the Prisoner Ombudsman's investigation is to find out, as far as possible, what happened and why, establish whether there are any lessons to be learned and make recommendations to the Northern Ireland Prison Service (the Prison Service) and the South Eastern Health and Social Care Trust (the Trust) for improvement, where appropriate.

By highlighting learning to the Prison Service, the Trust and others who provide services in prisons, the Ombudsman aims to promote best practice in the care of prisoners.

Investigation objectives are set out in the Ombudsman's terms of reference and are to:

- establish the circumstances and events surrounding the death, including the care provided by the Prison Service;
- examine any relevant healthcare issues and assess the clinical care provided by the Trust;
- examine whether any changes in Prison Service or Trust operational methods, policy, practice or management arrangements could help prevent a similar death in future;
- ensure that the prisoner's family have an opportunity to raise any concerns they may have, and take these into account in the investigation; and
- assist the Coroner's investigative obligation under Article 2 of the European Convention on Human Rights, by ensuring as far as possible that the full facts are brought to light and any relevant failing is exposed, any commendable practice is identified, and any lessons from the death are learned.

Within the above objectives, the Ombudsman will identify specific matters to be investigated in relation to the circumstances of an individual case.

In order that learning from investigations is spread as widely as possible, and in the interests of transparency, investigation reports are published on the Prisoner Ombudsman's website following consultation with the next of kin. Reports are also disseminated to those who provide services in prisons.

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GLOSSARY

AD: EPT	Alcohol and Drugs**:** Empowering People Through Therapy
AED	Automated External Defibrillator
BLS	Basic Life Support
CCTV	Closed-circuit Television
CPR	Cardiopulmonary Resuscitation
CSI	Crime Scene Investigator
ECR	Electronic Care Record
FMO	Forensic Medical Officer
ILS	Intermediate Life Support
IMB	Independent Monitoring Board
IRC	Immigration Removal Centre
OCD	Obsessive Compulsive Disorder
OPG	Orthopanthomogram
PACE	Police and Criminal Evidence (Order) NI
PECCS	Prisoner Escorting and Court Custody Service
PER	Prisoner Escort Record
PSNI	Police Service of Northern Ireland
PRISM	Prisoner Record and Inmate System Management
PREPS	Progressive Regimes and Earned Privileges Scheme
PRRT	Police Rehabilitation and Retraining Trust
PSST	Prisoner Safety and Support Team
RGN	Registered General Nurse
RMN	Registered Mental Health Nurse
RQIA	Regulation Quality and Improvement Authority
SEHSCT	South Eastern Health and Social Care Trust
SPAR	Supporting Prisoners At Risk (procedure)
The Prison Service	The Northern Ireland Prison Service
The Trust	The South Eastern Health and Social Care Trust

Foreword from the Ombudsman

Introduction

Mr Jonathan Stewart was remanded into custody at Maghaberry Prison on 15 March 2017. He died on 17 May 2017 in Lagan House having moved from Quoile House on 12 May 2017. Mr Stewart was 38 years old when he died and as his death happened while he was in custody I am required to investigate and report on the circumstances surrounding his death.

This investigation was conducted in line with the Terms of Reference for the Prisoner Ombudsman NI's investigations of Deaths in Custody (Appendix 1), which include providing explanations, where possible, to Mr Stewart's family.

My investigation

The post-mortem report records the cause of Mr Stewart's death as being due to an 'Incised Wound to the Neck.'

It is for the Coroner to consider the cause of Mr Stewart's death while my investigation seeks to establish the circumstances surrounding his death. I hope that the information I have provided will help the family piece together the last events in Mr Stewart's life. I commissioned an independent Clinical Review to consider the healthcare Mr Stewart received and the outcome of that review is contained within my report. Terms of Reference for the Clinical Review can be found at Appendix 2. I make a number of recommendations focussed on learning to improve the care of all those in custody in light of what happened to Mr Stewart.

Overview of events leading up to Mr Stewart's death

Mr Stewart was accommodated in Bann House, the committal House that provides those coming into custody time to orientate themselves to their situation and receive necessary assessments and information. From there he moved to Quoile House on 12 March 2017 and then, on 12 May 2017, to Lagan House. From my investigative enquiries I have established that Mr Stewart had been concerned about his oral health and Prison Officers in the various locations where he had lived within the prison were aware of it. Prison Officers had reassured him he did not have bad breath and he requested and was granted several visits to the dentist. This matter will be discussed further in the body of my report.

Those Prison Officers who interacted with Mr Stewart said he was polite and well mannered. They could not remember any interactions that would have caused them concern about his wellbeing.

Mr Stewart made no telephone calls during his last time in custody. He maintained contact with his family and girlfriend by letter and through visits. Regular visits are recorded with both his father and his girlfriend and on the day before he died he had a visit with his girlfriend and her son.

During his time in custody in 2017 Mr Stewart made six requests. Three were about the possibility of securing a hostel place as he was keen to enhance his prospects of bail. As is recorded in my report, his solicitor assisted with securing a bail address. One other request was about property and the final two were about telephones.

As Mr Stewart was in custody for a relatively short period of time he was on standard regime and he had not been drug tested, employed or attended education. He did attend his induction programme, apart from the Housing and Safer Custody modules as facilitators were not available. The Housing appointment was later followed up.

Mr Stewart made purchases from the tuck shop, including a razor, and there is nothing unusual or unexpected on his tuck shop list. All items found in his cell were consistent with what he had bought from the tuckshop.

Mr Stewart was quiet and often kept to himself. Both Prison Officers and others in custody found him to be content in his own company. On some occasions, for example, he did not take the opportunity to spend time in the yard. He was very settled in Quoile House and others in custody suggested that he found the move to Lagan House difficult, particularly as he had been moved away from some of his friends. Some other friends moved with him to Lagan House.

Most accounts from other individuals in custody described Mr Stewart as being reserved and likable. Two individuals in custody, with whom he spent more time in Quoile House, Individual B and Individual C, reported that he seemed to feel safe and settled there. They did not know each other beforehand but got on well together. Individual C said Mr Stewart loved to chat about fishing and motorcycling and generally enjoyed a social chat.

Individual C reported that Mr Stewart would stand at a distance when talking because he believed he had 'bad' breath. He also thought Mr Stewart's concern about this was the reason he did not later use the yards in Lagan House. Individual B reported that Mr Stewart believed he was likely to serve a long sentence but he did not speak in any great detail about why he was in prison. Both Individuals B and C were very shocked when they heard of Mr Stewart's death. They recounted an incident when another individual in custody had self-harmed by cutting themselves and Mr Stewart said that people who did that should not be in prison.

Another individual in custody who had moved with Mr Stewart from Quoile House to Lagan House, Individual D, said Mr Stewart was very much in love with his girlfriend and the relationship played on his mind.

Mr Stewart's family shared copies of the letters he had written to them with my investigator. Most of them demonstrate frustration about aspects of the prison regime and the challenges of achieving bail. At other times he seemed resigned to remaining in prison. Two incoming letters – one from his girlfriend and the other from his sister - were found in his cell after his death.

In total Mr Stewart had five visits while he was in Maghaberry Prison. His father and girlfriend visited him on alternate occasions apart from once when they visited together. One visit with his girlfriend was cut short due to tea being drunk from a cup without a lid which contravened a new security policy. All other visits lasted the normal duration. Mr Stewart's father had a visit scheduled with his son on 02 June 2017.

My report

The publication of this report has been significantly delayed. While the investigation had completed and a final report was drafted, matters of concern remained for the family and to provide them space to deal with these concerns my Office agreed not to publish this report on 2 occasions. On the occasion of the second delay I undertook to ensure my investigation answered, as far as possible, the questions Mr Stewart's family had relating to matters specifically within my remit. In light of conversations with the family and further consideration of their questions I have updated this report. I do not believe I can add any further information to matters within my remit and I must be careful not to stray into the remit of others. There is no doubt this can be challenging for families who are, understandably, focussed on getting as many answers as possible.

I am conscious of the ongoing concerns the family have and of the particular focus my investigation necessarily takes in comparison to the Coroner's investigation which draws on a number of independent investigations, including mine. The Coroner is keen to complete inquest proceedings that will conclude on the cause of Mr Stewart's death. I am conscious that Mr Stewart's family have lived with a deep sense of loss and with ongoing questions since his death. I have taken the decision, in consultation with the Coroner, to proceed to publication to allow proceedings to progress. The family expressed a concern that the publication of my report could prejudice a jury. This is a matter for the Coroner with whom I collaborate in relation to report publication. The Coroner is content that I proceed and will address the family's concerns when a jury is selected.

I acknowledge again the sense of loss Mr Stewart's family continue to feel and their belief that he should still be alive. I again offer them my condolences and hope that the inquest will assist them further.

Given the significant passage of time since this report was first drafted and recommendations made, I have also updated information in relation to recommendations, removed one recommendation which had been addressed and added a new recommendation.

DR LESLEY CARROLL
Prisoner Ombudsman for Northern Ireland

Section 1: Recommendations

1.1 Recommendations List and Factual Accuracy Responses

Recommendation 1: Fabric Checks
The Prison Service should remind Residential Managers that, in line with instructions, they should properly complete records of fabric checks on every occasion.

The Prison Service accepted this recommendation

Recommendation 2: Preserving the scene of a death in custody
The Prison Service should complete a review of procedures for preserving the scene of a death in custody, update them where required to ensure robust protection of the scene and communicate any changes to procedures to relevant staff and managers and provide my Office with an update when this has been completed.

The Prison Service accepted this recommendation

Recommendation 3: Life Support
The Trust (Healthcare in Prison Service Managers) should ensure that staff training and refreshers are up to date and in line with *Resuscitation Council UK Quality Standards for CPR Practice and Training* (May 2017) and Trust Policy.

The Trust accepted this recommendation
Update:

- All frontline healthcare in prisons staff receive mandatory Basic Life Support (BLS) training.
- Frontline nursing staff are trained in Immediate Life Support.
- Basic Life Support Training takes place annually and Immediate Life Support Training on alternate years
- Only staff trained in Advanced Life Support can determine if CPR can be ceased.
- All levels of training are in line with *Resuscitation Council UK Quality Standards for CPR Practice and Training*.

Section 2: Background information

2.1. Maghaberry Prison

Maghaberry Prison is a high security prison which holds male, adult sentenced and remand prisoners.

Since 2008, the Trust has provided prison healthcare services. There is a 24 hour primary care service. The primary care staff all have some Mental Health training in addition to their core training. The Mental Health Team was on site Monday to Friday 08:00-17:00 at the time of Mr Stewart's death. Since 30 October 2020 the Mental Health Team commenced a pilot to provide a service 7 days a week in Maghaberry Prison. I recognise that staffing this can be challenging as it requires stretching the original 5 day staffing resource over 7 days. The commissioners are aware of the need for more funding to guarantee a 7 day service across all sites. Since October 2020 all mental health committal screen triage takes place face to face.

At 08:00 on 16 May 2017, 18 persons in custody across Maghaberry Prison were being managed under SPAR (Supporting Prisoners At Risk) arrangements and this had increased to 23 by 08:00 the following morning. There were 3 people on SPARs on Landings 3-6 within Lagan House (the upstairs Landings), including one in an observation cell, none on Landing 6 itself. There had been a number of discipline alarms and medical emergencies on 16 May 2017 including an attempted suicide in the prison's Care and Supervision Unit.

On 16 May 2014, there were 830 people in custody at Maghaberry Prison.

2.2 Criminal Justice Inspection (CJINI)

The most recent inspection report of Maghaberry Prison was carried out in April 2018 and the report was published in November 2018. Inspectors reported that the prison had settled considerably since the last full inspection in May 2015 and was a much safer place.

Inspectors reported that the overall picture of safety had progressed and that levels of violence and disorder had reduced. They remained concerned that work to support the most vulnerable individuals in custody had not developed to the same level as other aspects of safety. Health care provision was much improved and was assessed by Inspectors as being reasonably good based on the 4 tests of a healthy prison.[1]

[1] The 4 tests of a healthy prison are – **Safety**: those in custody, particularly the most vulnerable, are held safely. **Respect**: those in custody are treated with respect for their human dignity. **Purposeful activity**: those in custody are able, and expected, to engage in activity that is likely to benefit them. **Rehabilitation and release planning**: those in custody are supported to maintain and develop relationships with their family and friends, helped to reduce their likelihood of re-offending and their risk of harm is managed effectively and they are prepared for their release back into the community.

2.3 Independent Monitoring Board (IMB)

Maghaberry Prison has an IMB whose role is to satisfy themselves regarding the treatment of individuals in custody, facilities available to them for purposeful activity and the cleanliness and adequacy of prison premises. In their 2020 – 2021 Annual Report the Maghaberry Prison IMB drew attention to a number of matters relevant to this investigation, including:

- Welcome for the continued reduction of illegal drugs coming into the prison;
- Concerns about the availability of footage of incidents due to shortcomings in procedures and processes;
- A stable and safe environment provided by the prison regime.

They also acknowledged the improvement provided by the newly opened Davis House in February 2020 which has improved the standard of accommodation on site and led to some of the old 'square' houses being closed. Lagan House was among those that were closed but it had to be re-opened to assist with pressures arising from the Covid-19 pandemic.

2.4 Prisoner Escorting and Court Custody Service (PECCS)

PECCS is the Prisoner Transport and Escorting Service. PECCS also has responsibility for the safe operation of the cell holding areas in each Courthouse in NI.

2.5 Previous incidents at Maghaberry Prison

Mr Stewart's death was the only apparently self-inflicted death at Maghaberry Prison during 2017.

PART A: INVESTIGATION AND FINDINGS

Section 3: Framework and scope for investigation

3.1 Questions raised by Mr Stewart's family

Mr Stewart's family met with one of my predecessors on 24 May 2017. For a number of reasons publication of the final investigation report was delayed. In order to further my investigation, I met with Mr Stewart's family on 04 April 2022. It was a valuable opportunity to listen to their concerns and discuss the scope of their questions with them. I have listed their questions at Appendix 3 and address these throughout my report.

3.2 Investigation methodology

My investigation methodology is designed to thoroughly explore and analyse all aspects of each case including any questions raised by bereaved relatives. Notices of investigation into Mr Stewart's death were issued to relevant parties on the day of his death, including to individuals in custody, the Prison Service, IMB and Prison Healthcare. Notices of Investigation allow those wishing to provide information or witness statements to come forward. The following information was gathered and analysed by the Investigating Officer:

- Prison Service records including relevant Closed-Circuit Television (CCTV) footage and radio transmissions;
- Interviews with prison and healthcare in prisons staff;
- Interviews with individuals who were or had been in custody; and
- Prison healthcare records.

All of this information has been carefully examined and I have detailed the relevant matters underpinning my findings, in this report.

3.3 Independent advice regarding Clinical Care

When appropriate, I commission an independent Clinical Review of specific aspects of healthcare provision. A Clinical Reviewer is commissioned from an agreed list, usually to provide peer review, and they supply a report with recommendations. My Office provides the Clinical Reviewer with relevant documentation and Terms of Reference specific to each case to enable them to provide an independent, expert opinion about the care received by the individual in custody. A Clinical Reviewer may, for example, assess delivery of care in relation to current clinically approved

guidelines, local and national and/or policy and practice within the relevant prison. They will keep in mind whether or not care has equivalency with that provided in the community and any learning to improve care in the future. By equivalency I do not mean that care should be the same as that provided in a community setting but rather that the care should be at least equivalent and take the constraints of the custodial environment into account.

Ms Jane MacKenzie[2] was commissioned to provide an independent Clinical Review of the healthcare provided to Mr Stewart. Her Terms of Reference can be found at Appendix 2. Ms MacKenzie provided me with a report setting out her opinion on the matters she was asked to consider. I have included her opinion on relevant healthcare matters in this report.

3.4 Scope and remit of this investigation

The objectives of this investigation must meet the standards set out in Terms of Reference for Prisoner Ombudsman NI investigations of deaths in custody (Appendix 1). These, together with the Terms of Reference for the Clinical Review and questions the family have asked, form the objectives of this investigation which are to:

•	Provide a timeline of events leading up to Mr Stewart's death;
•	Establish the circumstances and events surrounding Mr Stewart's death and as far as possible provide explanations and insight for Mr Stewart's family;
•	Examine whether Mr Stewart's health care and mental health needs were appropriately managed in prison, including whether any potential signs were missed which could have predicted or prevented Mr Stewart's death;
•	Establish any learning from events around Mr Stewart's death and identify good practice;
•	Assist the Coroner's inquest in achieving fulfilment of the investigative obligation arising under Article 2 of the European Convention on Human Rights, by ensuring as far as possible that the full facts are brought to light and any relevant failing is exposed, any commendable action or practice is identified, and any lessons from the death are learned.

[2] Ms MacKenzie MSc RN (G), RMN is a retired Registered Mental Health Nurse and (RMN) and Registered General Nurse (RGN) who has extensive experience of working in mental health services in England and Wales. She is a member of the Health Inspectorate Wales Team and has experience of conducting clinical reviews of prison deaths in Wales.

Section 4: Chronology of events and timeline of responses up to 15 May 2017

4.1 Events and responses

My investigation and assessment of Mr Stewart's care is assisted by a chronology of events leading up to his death, including staff responses when Mr Stewart was found in the early hours of 17 May 2017. I will also seek to answer specific issues raised by Mr Stewart's family. This will include:

- Why was Mr Stewart moved from Quoile House, where he was happy, to Lagan House where he was not? The family have a perception that a lot of drugs were available in Lagan House and therefore it was not appropriate for someone with addictions to be housed there;
- Had Mr Stewart any contact with chaplaincy support at Maghaberry Prison?
- Mr Stewart had made a number of requests for telephone access to contact family members. Were these dealt with appropriately by the Prison Service?

4.2 From committal on 15 March 2017 to 15 May 2017

Mr Stewart was remanded into custody from Craigavon Magistrate's Court on 15 March 2017. He had been in prison on 2 previous occasions and during both those periods in custody no concerns regarding his mental health were identified. Consequently, he was never managed under the SPAR procedures which set out specific responses and supports for those individuals in custody who are assessed to be particularly vulnerable to self-harm / suicide.

The documentation given to prison reception staff by those who escorted Mr Stewart from Court to Prison comprised:

- The Prison Service New Committal Form, produced by PECCS
- PSNI Police and Criminal Evidence Order NI PACE 15 Detained Person's Medical Form
- PSNI PACE 15/2 Detained Person's Medication Form
- PSNI PACE 16 PER (Prisoner Escort Record) Form, which included vulnerability information and custodial information

Documentation from the PSNI, received at his committal, indicated that Mr Stewart had a history of self-harm/suicidal tendencies and the possibility that he might try to bring drugs into prison. It also stated that he had no current thoughts of self-harm and had no cash, medication or property.

The PACE document provided information about the period Mr Stewart was in police custody. He was recorded as being compliant and calm. Mr Stewart reported he was not on any medication or drugs and was sober. The record indicates he was '*Flagged for self-harm and drug user from 2008 – no current thoughts*.' Records show that he raised no issues about mental health problems, depression, whether he needed to see a healthcare professional or if there were signs that he had inflicted self-harm. Other than stating he wanted his solicitor informed, Mr Stewart said he did not want anybody informed of his arrest at that time.

Prison Officer C completed the reception interview and produced the Prison Service committal summary which was placed in the residential file. This summary provides staff with information about vulnerability, substance/alcohol misuse and is intended to highlight key information to residential staff about an individual so that their needs and risks can be appropriately managed during their early days in custody.

Maghaberry Prison staff are advised, regarding Committal Documentation, to ensure accurate records are maintained on the Prisoner Record and Inmate System Management (PRISM); and where PACE 15 and 16 forms are received, they must be accurately documented and their content transcribed onto the relevant committal screen. Reception staff and committal nurses are required to ensure that the information contained on PSNI forms is given adequate weight and actioned accordingly.

In this instance, Prison Officer C, the Reception Officer, noted that the PSNI documents had been received. Prison Officer C explained that as the PSNI document had referenced prior self-harm but no specific act of self-harm or background detail, this was not flagged on the committal summary. Prison Officer C explained that people can present and behave differently in police custody than in prison custody. At the committal interview the risk of self-harm is queried as part of a vulnerability assessment. Mr Stewart replied 'No' to questions about risk of self-harm, whether anything had happened recently to increase thoughts of self-harm or suicide, involvement with mental health services and if he required immediate help. He confirmed he had used heroin and cocaine and said the last time he used drugs was more than a year ago. He stated he was not currently suffering from withdrawal from drugs or alcohol.

Overall, based on Mr Stewart's responses during the committal interview, the checks done on PRISM and assessment of how he was presenting, Prison Officer C concluded Mr Stewart '*Presented well throughout interview and gave no indication of being currently vulnerable*.' Prison Officer C recognised it was important to consider not only what a person said at interview, but also how they said it and following interview Prison Officer C had no concerns about Mr Stewart.

A cell sharing risk assessment was also completed by Prison Officer C, and no issues were identified.

Trust staff complete an Initial Health Screen usually within 4 hours of his arrival at the prison. This is followed by a Comprehensive Health Screen within 72 hours. The purpose of the Initial Health Screen is to keep an individual in custody safe during the early stages of their time in custody. Nurse A completed the Initial Health Screen and the Initial Committal Screening Form, which records initial health information, obtains consent to share information and notes medical markers to inform care, within 4-hours.

Nurse A interviewed Mr Stewart and records show previous incidents of self-harm were explored and that he said he had cut himself once 15 years previously but he had no current thoughts of self-harm. Records also show that he disclosed he had previously been a heroin addict but he had not used drugs for 8 years. He was offered, but declined, a referral to Alcohol and Drugs: Empowering People Through Therapy (AD:EPT), the prison's drug and alcohol support service. The notes from the PSNI documentation were accurately recorded. Mr Stewart asked to see a dentist and the Nurse advised she would enrol him. The Nurse accessed the Electronic Care Record (ECR) and confirmed that Mr Stewart was not on any medication in the community at that time.

The following day, 16 March 2017, Nurse A, completed a Comprehensive Committal Assessment. Nurse B completed the Initial Mental Health Screen which comprises a review of committal assessments. Nurse B recorded that there was no indication for mental health assessment at that time and noted: '*Refer via mental health pathways if later clinically indicated*.' The dental referral Mr Stewart had requested the day before was also made and Mr Stewart had a visit with his father.

On 20 March 2017 both his Committal Induction and Medication Administration Record Card were completed. Mr Stewart saw the Dentist which I will discuss further in Section 6.

On 21 March 2017 Mr Stewart attended gym and manual handling inductions. On 23 March 2017 he saw Nurse C about a medical condition.

From his arrival into Maghaberry Prison until 24 March 2017 Mr Stewart was accommodated in Bann House. On 24 March 2017 Mr Stewart had a video link court appearance and that same day he moved to Quoile House, Landing 2. Senior Officer B completed a cell-sharing risk assessment. Mr Stewart shared a cell for a day or part of a day. On 30 March 2017 he again saw Nurse C. On 31 March 2017 he had a further video link court appearance.

Prison Officer D from Quoile House, confirmed Mr Stewart seemed to settle well and said Mr Stewart was always friendly and polite and never in a bad mood. He had no concerns about him.

During his time in custody Mr Stewart was keen that arrangements were made for his release back into the community and it was important to him that bail arrangements were agreed. He had an appointment about housing arrangements on 03 April 2017.

On 07 April 2017 Mr Stewart had a video link court appearance and was moved to a new cell in Quoile House, also on Landing 2. On 11 April 2017 he had a family visit and on 12 April 2017 Mr Stewart had a dental review with Dentist A.

Mr Stewart had 2 visits: a family visit on 20 April 2017 and a legal visit on 25 April 2017.

On 26 April Mr Stewart had an appointment with Doctor A.

Mr Stewart's next video link court appearance took place on 05 May 2017. On 09 May 2017 he presented to Nurse D with toothache for which he was given paracetamol.

On 10 May 2017 Mr Stewart attended a legal visit and a further housing needs appointment as he remained on the waiting list for a bail hostel. However, Mr Stewart had completed a hostel referral form with his solicitor that morning; no further action was necessary and an appropriate record was made.

Mr Stewart attended an appointment with Dentist B on 11 May 2017 for a second opinion.

On 12 May 2017, Mr Stewart was moved from Quoile House to Lagan House, Landing 6, along with 8 others. This was to accommodate the relocation of the 'Lagan Project' to Quoile House. His Progressive Regimes and Earned Privileges Scheme (PREPS) history was completed on 12 May 2017 by Prison Officer E who recalls that day as being busy because of the new arrivals onto the Landing. There were not normally that number of people arriving onto a Landing at once and staff were busy sorting out bed packs, televisions and other items for their cells. Prison Officer E explained that when someone new comes onto the Landing staff receive a handover and the individual in custody's residential wing file. The receiving staff check the file to see if there is anything they need to be aware of. Staff also complete a fabric check to ensure there is no damage to the cell and that lights and the cell bell are all working properly. Staff then explain the Landing routine to the new arrivals.

Individual C was moved to Lagan House on 12 May 2017 although Mr Stewart was not aware of this as he was at court when the move took place. Individual C recounted that Mr Stewart was relieved to hear that he was in the adjacent cell given the friendship they had established in Quoile House. They talked out the windows over that weekend before Individual C was moved to another location the following Monday. Individual C said when Mr Stewart realised he was to move again he just went silent.

On 15 May 2017, Prison Officer E was on duty and had a conversation with Mr Stewart about bad breath. Prison Officer E recalled that when Mr Stewart spoke, he usually covered his mouth with his hand. On one occasion, as Mr Stewart went to get

his evening meal, Prison Officer E was walking alongside him and he advised the Officer not to walk too close to him because he had very bad breath. Prison Officer E reassured him this was not the case and he explained that although he had been to the dentist and had been told there was nothing wrong, he could still smell and taste it. Prison Officer E recalled he seemed quite annoyed because of what other people might think about his breath. On another occasion he was concerned about the smell in his cell. Prison Officer E, who had been in his cell, reassured him there was no smell.

Prison Officer E had also been on duty at the weekend and recalled a number of interactions with Mr Stewart. Mr Stewart and a number of others declined to go to the yard. The Prison Officer believed this was due to the fact that they had only recently moved into the House and were getting acquainted with their new location. Prison Officer E said that Mr Stewart seemed to be quite happy to watch television in his cell although there had been times when they had observed him chatting with Individual D when they were out on the Landing together.

Prison Officer F also recalled a conversation with Mr Stewart during the weekend when he had spoken of his concern that people would think his oral hygiene was poor. Prison Officer F remembered the conversation because Mr Stewart had covered his mouth with his hand when he was talking.

Apart from these conversations the Lagan House, Landing 6 Prison Officers did not recall any other significant interaction with Mr Stewart apart from routine engagement about the daily regime in the House. At no time did he appear to them to be agitated or distressed and they had no concerns about his wellbeing.

4.3 Family questions

Mr Stewart's family asked particular questions relating to his time in custody up to 16 May 2017.

1.	Why was Mr Stewart moved from Quoile House where he was happy to Lagan House where he was not?
From conversations with Mr Stewart's family it is clear that they have a perception that drugs were available in Lagan House and this led them to question why Mr Stewart was moved from Quoile House to Lagan House. Mr Stewart was initially accommodated in Bann House and after 2 weeks was moved to Quoile House rather than directly to Lagan House most likely because there were space constraints. On 12 May 2017 he moved to Lagan House along with 8 others.[3] The move from Quoile House was necessary due to the re-	

[3] Lagan House is mainly a remand House and the Landings are not designated for a specific purpose. It generally holds around 130 individuals in custody and on 16 May 2017, Landing 6 had 22 individuals.

designation of Landing 6 in Lagan House. Up until early May 2017 this Landing had accommodated the Lagan Project – a Quality Improvement Project jointly delivered by the Prison Service and the Trust that focussed on pain management and reducing dependence on the use of pain medication. The Project was relocated to Quoile House resulting in moves to make the required room. As would be normal practice, the Maghaberry Prison security department identified the individuals in custody, including Mr Stewart, to be moved. He was allocated Cell 15 with people nearby whom he had been friendly with while in Quoile House. When committed into custody, Mr Stewart had been transparent about his past use of drugs. He also stated that he had not used drugs for some years and he refused a referral to AD: EPT. His family confirmed that he had not used drugs for a number of years.

In the course of interviews some individuals in custody speculated about what might have triggered Mr Stewart to harm himself on 17 May 2017, including the possibility of drugs contributing to his behaviour. There is no evidence that drugs played a part in Mr Stewart's actions. No illicit substances or alcohol were found in his system following his death.

The move to Lagan House was in line with procedures.

Mr Stewart was accommodated in Lagan House for 16 days before his death.

2. Had Mr Stewart any contact with chaplaincy support at Maghaberry Prison?

There is no record of Mr Stewart having contact with chaplaincy services during his time at Maghaberry Prison.

3. Mr Stewart had made a number of requests for telephone access to contact family members. Were these dealt with appropriately by the Prison Service?

Mr Stewart did not make any telephone calls during his 9 weeks in custody. During those 9 weeks he made 2 requests related to telephones. The first, made on 16 March 2017, was to have his old numbers reactivated from his previous telephone list in 2015. The request was sent back to him explaining that he needed to provide the list. The Prison Service do not retain lists from previous periods in custody for data protection reasons.

The second request, made on 24 April 2017, was a request for a replacement pin card as Mr Stewart had lost his. A telephone card was listed among the belongings in his cell after his death.

It appears that Mr Stewart's requests for telephone access were appropriately dealt with.

Section 5: Events, circumstances and Prison Service responses, Lagan House, 16 and 17 May 2017

5.1 The day leading up to Mr Stewart's death

This section will examine events on 16 May 2017, the day immediately leading up to Mr Stewart's death, look at the responses provided by both Healthcare in Prisons and the Prison Service when Mr Stewart was found unresponsive in his cell and their later responses after Mr Stewart died. I will also consider questions raised by Mr Stewart's family:

- Why did Mr Stewart have blades in his cell?
- Three notes were found in Mr Stewart's cell. Were they written by Mr Stewart? Where were they found? Where are they now?
- What changed from the visit on 16 May 2017 when Mr Stewart appeared fine that could have caused him to self-harm later that night?
- What time did Mr Stewart die?
- Mr Stewart had a diary in his cell with unknown numbers in it. To whom did the numbers belong?
- Had the emergency cell bell been tested on 16 May 2017 and why was there blood on it after Mr Stewart's death?
- Should the critical matter of CCTV availability be addressed by a recommendation?
- Was it appropriate for the cell door to be opened by an unaccompanied Prison Officer?
- Was an individual in custody's complaint, about hearing Mr Stewart banging and not being responded to, handled properly through the Internal Complaints Process?

5.2 Events on 16 May 2017

Landings 5&6 within Lagan House would usually have 3 staff on the Landing during the day and this was the case on 16 May 2017. There are 2 observation cells on Landing 5 where vulnerable individuals in custody can be kept safe. The general House regime entails those required for early court appearances being unlocked at around 08:30, followed by anyone who has early appointments. Individuals in custody attending education or work leave the House around 08:45. Up to this point anyone who is not leaving the House remains locked. Staff then unlock 4-5 individuals in custody at a time to do a variety of things including showering, cleaning their cells and organising their tuck shop. Staff also take requests as individuals are unlocked.

Once these tasks are completed individuals in custody can access the yards, use the recreation room and telephones. Yard access is rotated on a daily basis. Those who decide not to make use of the yard facilities can request to be allowed out of their cells and staff aim to facilitate reasonable requests.

Lunch is served at 11:45 and the Landings are usually locked from 12:30 until 14:00 when the afternoon unlock is announced. The afternoon regime is similar to that in the morning, with individuals in custody unlocked to attend activities and yards. Landings are briefly locked again at 16:30 for a short period before the evening meal is served at a servery. Access to the yards is available on alternate evenings before cells are finally locked at 19:30. If an individual in custody does not attend activities or go to the yards, he will remain locked unless he requests to be unlocked.

At night, 1 Prison Officer is responsible for the 4 upstairs Landings within Lagan House i.e. Landings 3-6, a second Prison Officer covers Landings 1&2 and a third supervises the control pod at the entrance to the House. On the night of the 16/17 May 2017, the Landing was fully staffed and the regime on Landing 5&6 was typical.

The Class Officer's journal records that permission to unlock was given at 07:55 and those attending workshops and education were called to leave the House at 08:45. Landings were locked at 12:20 over the lunch period and unlocked again at 13:45 for afternoon activities. Lagan House, Landing 6 residents were offered time in the yard during the afternoon. The journal records the evening meal was served at the servery at 17:10. The Landings were then locked and numbers returned by day staff at 19:25.

The first task for staff coming on duty is to conduct security checks which includes an examination of the structure of cells and testing cell alarms. On 16 May 2017 these were not recorded in the Class Officer's journal as having been completed although the documentation is signed. Completed checks were fully signed on the previous day. It is important that records are properly kept, in line with instructions. It is likely that the checks were completed because the documentation is signed but it is impossible to say this with complete certainty.

Whether or not Mr Stewart's bell was working has been an issue for the family. The concern may have been contributed to by a bloody mark on a switch in the cell which I will address later in Section 8.5. It is likely, from the available record of checks and normal procedural processes, that Mr Stewart's cell bell was working but the confidence the family require is lacking due to incomplete records. Given the family's concern about whether or not Mr Stewart attempted to use his cell bell overnight on 16/17 May to call for help I make the following recommendation:

Recommendation 1: Fabric Checks

The Prison Service should remind Residential Managers that, in line with instructions, they should properly complete records of fabric checks on every occasion.

Three staff were detailed to Lagan House, Landings 5&6 on 16 May 2017. One Prison Officer was on Landing 6 most of the day. The other two either worked from the Class Office or Landing 5, although they helped each other out as necessary during the day. Prison Officer G, who was mainly on Landing 6, recalled no issues with Mr Stewart that day beyond routine interactions.

On the morning of 16 May 2017, 09:19-10:25, Mr Stewart had a visit with his girlfriend and her son. From CCTV footage of the visit this appears to have been a happy visit with good engagement between all present. The visit lasted for over an hour and included refreshments. Mr Stewart's girlfriend brought him new trainers and said he had been in a good place on the visit and asked her to tell his father he would like him to bring a lightweight tracksuit.

Visits were important as Mr Stewart maintained family contact either through visits or letters. Although there is no CCTV footage on Lagan House, Landing 6, the footage of Mr Stewart leaving and returning to the House, viewed by my Investigating Officer, confirms there did not seem to be anything untoward about his demeanour that morning. Landing 6 residents were offered time in the yard in the afternoon but staff and individuals in custody reported that Mr Stewart did not go.

Prison Officer F spent most of his shift on the 16 May 2017 in the Lagan House pod where his primary responsibility was to control incoming and outgoing movements. Prison Officer F explained that the person with this responsibility could be dealing with the movements of between 60 and 70 individuals in custody and they did not recollect anything untoward about Mr Stewart's demeanour on his way to and from Visits that day.

One of the Lagan House, Landing 6 orderlies, Individual E, recalls a number of interactions with Mr Stewart on 16 May 2017. Individual E did Mr Stewart's laundry that day and returned the clothes, later in the day, to his cell in plastic bags. Individual E reported Mr Stewart seemed okay at that stage but said Mr Stewart later seemed troubled when he came to the servery to collect his evening meal. Individual E said he and the other servery orderly, Individual F, did not have a chance to speak to him as they were busy serving the food.

Later in the evening, Individual E was accompanied by a Prison Officer while giving out water and remembered Mr Stewart standing in his cell. He looked distant but when the Prison Officer asked him if he needed anything he politely replied, 'No thank-you.'

On the evening of 16 May 2017, cells were locked from approximately 19:25. Three Night Custody Officers were on duty that evening, Prison Officer A, Prison Officer B and Prison Officer H. One Prison Officer was detailed to the pod, one to Landings 1&2 on the lower floor of the House and the third covered the upstairs Landings, Landings 3-6. It is important to note that the Prison Officers rotated through these posts during the night.

When coming on duty the Night Custody Officers receive a handover from day staff in respect of anyone on a SPAR or any other issues to note. They are required to carry out a full head count and body check and record this in the Night Custody Journal. The Landings were already locked prior to the Night Custody Officers coming on duty on the evening of 16 May 2017. Prison Officer B was on duty on Landings 4-6 from 19:30 to midnight and made the initial entry confirming numbers in the journal. At the handover there was no reference in the handover to any concerns about Mr Stewart. Prison Officer B was relieved by Prison Officer H at 00:05 who in turn was relieved by Prison Officer A at 02:00.

Three individuals in custody were being managed under SPAR procedures on the upstairs Landings and required individual observations being made at 15, 30 and 60 minute intervals respectively. In the early part of the evening Prison Officer B responded to 2 cell alarms at 20:11, on Landing 5, and 20:30, on Landings 3. Medication was issued to 1 individual in custody at 20:39, not on Landing 6.

Prison Officer B was detailed to Mr Stewart's Landing from lock-up until midnight and recalled hearing a knock or bang coming from Landing 6 when leaving the Class Office some time before midnight to check the 3 individuals in custody who were on SPARs. Prison Officer B reported that he called out and asked who it was but got no response so proceeded to complete his SPAR observation checks.

Prior to midnight, Prison Officer B conducted 3 patrol checks at 21:11, 22:11 and 23:12 and 1 body check at 23:45. Operating procedures require that patrol checks are made and recorded at hourly intervals, or more frequently as directed by the Governor. In addition to patrol checks, which require a Prison Officer to walk the landing and are recorded electronically, there are normally body checks which must ensure signs of life. Body checks should be completed once prior to midnight and once before 04:30. A response check is conducted by Night Custody Officers near the end of their shift.

After midnight, patrol checks were completed at 00:05, 01:04 and 02:07.

Where the Night Senior Officer is not available to supervise the body check, permission is given to conduct the check unsupervised. As Senior Officer A was dealing with a matter elsewhere in Lagan House, permission was given for an unsupervised check to be conducted. This check was completed by Prison Officer B and records show Mr Stewart was observed lying on his bed at about 23:43. This check entails the flap on a cell door being lifted and the Prison Officer shining a torchlight on the individual in their cell to observe bodily movement.

5.3 Events on 17 May 2017

At 02:00 Prison Officer A moved onto Landings 4-6. Senior Officer A arrived in Lagan House at 02:30. Usually both Landing Officers conduct the supervised body check

but as the Prison Officer downstairs was not aware Senior Officer A was in Lagan House, Prison Officer A continued with the checks, beginning on the upstairs Landings at approximately 02:30. Prison Officer A started on Landing 5 and worked round the upper floor, finishing on Landing 6. Prison Officer A opened the flap of Mr Stewart's cell and pointed the torch onto the bed. Mr Stewart was not on the bed or toilet, which is behind a screen located on the right hand side of the door. It was about 02:33.

Prison Officer A looked down and saw Mr Stewart lying face down with his head towards the cell door. There was a lot of blood. Prison Officer A tried to get a response from Mr Stewart before sending an urgent radio message to raise the alarm. The initial message was transmitted at 02:33:02 quickly followed by a Code Red[4] alarm at 02:33:31. At 02:34:54, Prison Officer A transmitted a further radio message to request permission to enter the cell. Senior Officer A gave permission and by the time Prison Officer A had unlocked the door Senior Officer A had arrived and they entered the cell within seconds of one another.

On arrival on Landing 6, Prison Officer B went to the Class Office, which is between Landings 5&6, switched on the Landing lights and fetched gloves. Senior Officer A went directly to the cell and requested an ambulance at 02:35:25. Senior Officer A and Prison Officer A pulled Mr Stewart onto the Landing so that they would have room to perform CPR, as is common practice in such situations.

Prison Officer A and Senior Officer A turned Mr Stewart onto his back and the Senior Officer started compressions. They noted significant blood loss and wounds to his legs, wrist and neck. Nurse E, who had been in the Healthcare Unit, initially responded to the urgent message at 02:33:54. After arriving on the Landing Nurse E quickly requested Nurse F, to bring the green lifeline bag.

The Nurses and Prison Staff continued CPR until paramedics arrived at 02:58. Nurse E inserted an airway and applied the automated external defibrillator (AED). The AED did not advise administering a shock at any stage and Mr Stewart remained unresponsive throughout their attempts to resuscitate him.

The first ambulance arrived at the prison at 02:51:10, and paramedics were on the Landing at 02:58. A second ambulance crew attended at 03:02:13. The first ambulance crew assessed Mr Stewart and tried to administer fluids[5] but were unsuccessful. At 03:19 paramedics indicated they had obtained an output and were

[4] Code Red is an emergency call out within the prison and defined in the Emergency Procedures During Periods of Lock Ups, Northern Ireland Prison Service Training policy, as the code used when a individual in custody is found with severe bleeding, e.g. evidence of fresh bleeding on clothing or cell floor

[5] Paramedics attempted an intraosseus infusion, directly into the marrow of the bone, as it had been impossible to gain intravenous access

liaising with Craigavon Area Hospital about transferring Mr Stewart but sadly things deteriorated and the paramedics recognised that life was extinct at 03:27.

5.4 Queries raised in relation to events on 16 and 17 May 2017

a. Mr Stewart's last visit

On 16 May 2017, Mr Stewart attended a morning visit with his girlfriend and her son. In the hours after his death it was initially reported by prison staff that this visit had only lasted 9 minutes and it had been a bad visit. This was not the case. CCTV footage shows Mr Stewart and his visitors smiling and talking normally with each other for just over an hour, 09:19-10:25. No tension is evident between the three of them. Mr Stewart hugged his girlfriend at the end of the visit, shook hands with her son and returned to Lagan House.

b. Prison Officer intervention on the night of Mr Stewart's death

On the day of Mr Stewart's death an individual in custody, Individual A on adjoining Landing 3, submitted a complaint through the prison's Internal Complaints Process raising concerns about the circumstances surrounding Mr Stewart's death. Individual A complained that the death had occurred due to a lack of intervention by Prison Officers. Individual A claimed Mr Stewart had been banging on his cell door in an attempt to get help and that he should have been put into a safer cell well before taking his own life. Individual A complained that this needed looked at as staff were at fault.

The complaint was dated 17 May 2017 and was appropriately entered onto PRISM on 19 May 2017. Complaints involving staff are passed to the Duty Governor for action rather than being dealt with by staff who are potentially the subject of the complaint. In this instance the complaint was properly passed to the acting Head of Residence and Prisoner Safety, Governor A, who had been the Duty Governor at the time of Mr Stewart's death.

Governor A interviewed the complainant on 19 May 2017 and, taking account of the information available, concluded the internal investigation. Governor A's assessment was that there was no information to substantiate what Individual A had alleged. Governor A completed the Stage 1 response to the complaint on 19 May 2017 and advised Individual A that the untimely death of Mr Stewart was the subject of a PSNI and Prisoner Ombudsman investigation and it would not be appropriate to make any further comment. Governor A gave an undertaking to forward Individual A's complaint to the relevant investigators which he promptly did that day.

Individual A received the Stage 1 response on 25 May 2017 and he escalated the complaint asking for confirmation that this complaint was subject to a PSNI investigation. The Unit Manager, Prison Officer B, received the Stage 2 complaint on 04 June 2017 and responded on the same day.

Individual A was interviewed for this investigation on 25 May 2017 and explained that it was the next day, when talking to Individual G while in the yard, that they discovered Mr Stewart had died. Individual A reiterated hearing someone banging their cell door and trying to seek the attention of staff for several hours on the night Mr Stewart died but Individual A said they did not know who it was. During Individual A's complaint interview with Governor A, the Governor suggested that it could have been a different person, someone not on Landing 6 within Lagan House, who had been making noise that night but Individual A did not agree. Whether or not the complainant agreed or disagreed with the Governor would not have impacted the progress of the complaint investigation. It was appropriate to halt the internal investigation process to allow the PSNI and my Office to complete investigations.

Eleven individuals in custody on Landing 6 within Lagan House were formally interviewed by my Investigating Officers in relation to what they heard that night. Throughout the period from 19:30 on 16 May 2017 until they were unlocked the following afternoon, all individuals in custody were locked in their cells with no visibility into other cells on the Landing or onto the Landing itself. Some suggested they could see a little through their door flaps which were not fully closed. The accounts of these individuals in custody varied: 8 reported hearing nothing untoward up until Mr Stewart was found and 3 supported aspects of Individual A's complaint.

Cell 14 on one side of Mr Stewart, who was in Cell 15, had 2 occupants both of whom had been released when interviews were conducted. My Office wrote to those who had left a forwarding address but no one came forward to give information to the investigation. Individual H, who occupied Cell 16 on the other side of Mr Stewart's cell, said he heard nothing during the night of 16/17 May 2017 and did not realise until the following afternoon what had happened.

Individual D, in Cell 17 2 cells away from Mr Stewart's, said they heard a bang or noise which sounded like something falling against a cupboard or locker at around 12:20-12:30 on 17 May 2017. This individual had also been released before the interviews were conducted. Another individual in Cell 13, Individual I, reported hearing a similar noise around the same time. Neither of these individuals in custody reported hearing Mr Stewart banging his door or asking for help during the early part of the night.

Individual G, who was accommodated opposite Mr Stewart in Cell 8, reported that they heard Mr Stewart ask prison staff to see a Nurse several times during the day before his death and again shortly after lock up that evening at around 20:00. Individual G recalled that Mr Stewart was told that he would need to wait until the morning.

Individual G stated that Mr Stewart knocked his cell door periodically from 20:00 until 23:30 but they were not aware if staff were on the Landing while Mr Stewart was knocking his cell door. Individual G's impression was that Mr Stewart was trying to

attract the attention of prison staff to get help. The last time Individual G said he heard a Prison Officer on the Landing was around 23:30, but they did not hear any communication between Mr Stewart and the Prison Officer at that time.

Individual G said he was aware that other individuals in custody on Landing 6 reported Mr Stewart had been calling out to staff and staff shouted back to him. However, Individual G had not heard staff shouting back. Individual G had a very clear recollection of hearing the resuscitation attempt and had taken notes about it and took the view that Mr Stewart was in the process of inflicting his wounds when he was found, though this is contrary to all other reports.

I have examined the complaint Individual A made and witness statements provided to my Office. It is evident that there are differing accounts of noises on the landing the night of Mr Stewart's death. Individual A's complaint was properly handled given that investigations were being carried out both by my Office and the PSNI.

There is no CCTV footage on Landing 6 within Lagan House to substantiate what anyone said happened that night. All staff, including Senior Officer A who was in the House on 3 occasions and Trust staff who were on the Landings to dispense medication, said their recollection was that the House was relatively quiet. Night journals have no record of there being an issue for Mr Stewart nor did he use his cell alarm bell to seek assistance on the night he died.

In the course of interviews some individuals in custody speculated about what might have triggered Mr Stewart to harm himself, including:

- the level of night checks;
- rumours about a bad visit;
- staff being delayed entering the cell due to difficulty accessing keys;
- a perceived lack of response to his requests for help in the days before his death;
- the regime in Lagan House at that time;
- the contribution of drugs;
- the move from Quoile House to Lagan House;
- the possibility of a long sentence; and,
- the attitude of newer prison staff towards people in custody.

While all of these possibilities were speculated as potentially having an impact on Mr Stewart there is no evidence that any had foundation.

What is evidenced from records is:

- that Night Checks were conducted in line with instructions;

- the CCTV footage of Mr Stewart's visit on 16 May 2017 did not show anything untoward;
- there was no delay accessing the cell when Mr Stewart was discovered lying on the floor;
- no illicit substances or alcohol were found in Mr Stewart's system following his death;
- none of the day staff recalled any requests from Mr Stewart for medical or mental health support on that day nor for him to be given access to another cell;
- Mr Stewart had at no time complained about the attitude of staff; and,
- as Mr Stewart had previously attended healthcare appointments he knew the process for making such appointments.

Several individuals in custody were critical of the impact of other individuals in custody 'crying wolf' and abusing the SPAR process, which reduced the time available to staff to respond to genuine requests for help. There is no doubt that Prison Officers were busy. Nevertheless, checks were completed appropriately and should Mr Stewart have needed assistance he could, for example, have spoken to the Prison Officer who lifted his cell flap for the check at 23:34 and saw him lying on the bed. At the same time CCTV would give confidence to findings and it is not available. The family have been keen for me to consider a recommendation about CCTV which is a reasonable request and would, in my opinion, be a reasonable recommendation. However, Lagan House is no longer in use and the new wings in Davis House are covered by CCTV so there is no benefit to such a recommendation. It is, though, important for the Prison Service to note that should Lagan House or any other of the older 'square houses' be called back into use that CCTV provision should be considered as a means of ensuring the safety of those housed there and to give confidence to families.

On the balance of probabilities, from the information available to me, I consider it to be unlikely that Mr Stewart had requested and been denied access to healthcare on 16 May 2017.

5.5 Family Questions

1.	Question about Mr Stewart's demeanour: What changed for Mr Stewart between his visit on 16 May 2017 when he appeared to be fine and the time when he self-harmed?
There is no evidence of anything happening to change Mr Stewart's demeanour. His visit, from CCTV records, shows a friendly and happy visit with his girlfriend and her son. While there is limited CCTV available, CCTV showing Mr Stewart's	

movement in and out of Lagan House raises no concerns. No other concerns or requests for help are recorded.

2.	**Question about access to razor blades: Why did Mr Stewart have blades in his cell?**

Mr Stewart had access to razor blades via the tuckshop. On 23 March 2017 he ordered a razor, Gillette Mach 3, and blades. Should an individual be considered 'at risk' as assessed through a SPAR (now SPAR Evolution), blades would be removed from them. Given that Mr Stewart was not on a SPAR, nor had he been during any of his periods in custody, it was in order that he was in possession of blades for his razor.

3.	**Questions about items found in the cell: Three notes were found in Mr Stewart's cell. Were they written by Mr Stewart? Where were they found? Where are they now? Mr Stewart had a diary in his cell with unknown numbers in it. To whom did the numbers belong?**

The 3 notes referenced were found in Mr Stewart's locked medication box. The family examined the letters and confirmed similarities between the writing contained in the notes and Mr Stewart's handwriting. The contents of the notes are perplexing given their religious content, Mr Stewart's disinterest in religion and lack of contact with chaplains. If an updated Cell Compact had been in place it may have been possible to confirm that Mr Stewart was issued with a key to the medication box and could have placed the notes inside the box. However, it has not been possible to confirm that he was issued with the key nor was the key located in his cell. These notes are now in the possession of investigators.

With regard to the unknown numbers in Mr Stewart's diary I have no information about whose they were.

4.	**What time did Mr Stewart die?**

Life was recognised as extinct at 03:27, 17 May 2017.

5.	**Had the emergency cell bell been tested on 16 May 2017 and why was there blood on it after Mr Stewart's death?**

Records for 16 May 2017 are not sufficiently clear to answer the question with certainty. On the balance of probabilities the check was completed given it is a daily routine and that documentation is signed. As the detail of what checks were completed is not fully recorded, I have made a recommendation.

6.	**Should the critical matter of CCTV availability be addressed by a recommendation?**

As Lagan House is no longer used to house those on remand and as most individuals in custody are now housed where there is CCTV, a recommendation is not required. A number of issues have been raised during the pandemic about the lack of CCTV available in older Houses that had to be brought back into use and these have been addressed in the course of investigations into complaints raised by individuals in custody and recommendations were made. Lagan House is now closed.	
7.	**Was it appropriate for the cell door to be opened by an unaccompanied Prison Officer?**
The Prison Officer who found Mr Stewart unresponsive radioed his request to enter the cell unaccompanied. He was granted permission and before he could access the cell another Senior Prison Officer arrived on the Landing and they entered the cell within seconds of each other. In a matter of minutes more staff, both prison and healthcare, also arrived. Actions taken were in line with policy and therefore appropriate.	
8.	**Was a prisoner's complaint, about hearing Mr Stewart banging and not being responded to, handled properly through the Internal Complaints Process?**
I have examined the complaint and witness statements. It is evident to me that there are differing accounts of noises on the landing the night of Mr Stewart's death. Given that other investigations were in progress by my Office and the PSNI, the complaint was handled appropriately.	

Section 6: Management of Mr Stewart's health care and mental health needs

6.1 Healthcare in prisons

This section will focus on Mr Stewart's healthcare needs, including mental health, needs and will consider the clinical review provided by Ms Jane MacKenzie. I will consider how Mr Stewart's healthcare needs were met during his time in custody and on the night of his death. The Terms of Reference for the Clinical Review are set out in Appendix 2. I will also consider support offered to staff and individuals in custody post-incident and address questions raised by the family:

- Is there any evidence that Mr Stewart was in a psychotic state?
- Was Mr Stewart able to access medical assistance when he requested it?

6.2 Health history and care in custody

Mr Stewart had been in prison on 2 previous occasions. During his periods in custody he had received medical and dental care. While in custody in 2015 he had reported a long term problem with a foul smell coming from his mouth but no cause was identified and he was advised it could be coming from his stomach. His concerns persisted and were the main source of concern for him during his time in custody in 2017.

At committal Mr Stewart was appropriately interviewed and assessed. He discussed his addictions and reported that he had not had a drink in some weeks. His family confirmed this and also informed me that he had been clean from drug use for about 8 years. Mr Stewart's family reported that he had an Obsessive Compulsive Disorder (OCD) but there is no record of this in his notes and no indication of any underlying mental health issues in prison records. The clinical reviewer was satisfied that the physical and mental health screening was appropriate to meet Mr Stewart's clinical care at the time and that there was nothing in these initial records to indicate any mental health issue.

Mr Stewart Comprehensive Healthcare Assessment was completed on 16 March 2017 and at that appointment he requested an appointment with the dentist as had concerns. Four days later, 20 March 2017, Mr Stewart had an appointment with Dentist A and at the appointment he explained about the bad taste he had in his mouth and his concerns about having a bad odour coming from his mouth. Dentist A examined him, took x-rays, descaled Mr Stewart's teeth and told him he could not detect an odour. As Mr Stewart had reported a history of [6]helicobacter, Dentist A prescribed a 3-day course of Metronidazole, gave him advice on oral hygiene and arranged to review Mr Stewart again in 2 weeks. Dentist A described Mr Stewart as being intense during the consultation. Given the persistent concern Mr Stewart had about his perceived condition and his concerns that others would be impacted it is understandable that he would have conveyed intensity.

Mr Stewart saw Nurse C twice regarding a medical condition, 23 March 2017 and 30 March 2017. Following the second appointment Nurse C referred him to the doctor.

On 12 April 2017 Mr Stewart attended his dental review with Dentist A and again complained about a bad taste in his mouth and expressed concern about an odour. Dentist A provided Mr Stewart with some advice about oral healthcare and hygiene and also referred him for a second opinion.

On 26 April 2017 Mr Stewart attended an appointment with Doctor A who noted Mr Stewart had a history of helicobacter and abdominal bloating. Mr Stewart spoke about his bad breath but Doctor A, like the dentist, was unable to detect an odour.

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[6] Helicobacter pylori, previously known as Campylobacter pylori, is a **gram-negative, microaerophilic, spiral (helical) bacterium** usually found in the stomach

Doctor A did note some catarrh and prescribed Omeprazole capsules and a nasal spray.

Mr Stewart's medication record card was updated the following day and an in-possession medication risk assessment was completed indicating he could be responsible for handling his own medication. Mr Stewart's Medication Record Card was completed the following day, 27 April 2017, along with a risk assessment for managing his own medication.

On 09 May 2017 Mr Stewart saw Nurse D as he had toothache. He was given paracetamol.

In response to Dentist A request for a second opinion, Mr Stewart attended an appointment with Dentist B on 11 May 2017. Dentist B carried out a full dental examination noting that Mr Stewart was adamant his teeth and gums were the source of the problem. As with the other practitioners who had seen Mr Stewart, Dentist B was unable to detect any bad smell from Mr Stewart's mouth. Dentist B made a referral for an Orthopanthomogram (OPG)[7] which would provide a more detailed dental picture than a routine dental x-ray and planned to review Mr Stewart after receiving results of the scan. The referral for this scan was promptly made but it had not taken place prior to Mr Stewart's death. It transpired the referral had been cancelled by the Radiology Department at Lagan Valley Hospital, on 17 May 2017, as it did not meet local guidelines. Dentist B was unaware of this development when interviewed and had intended to review Mr Stewart when results were available.

Records show that the referral for the OPG was followed up promptly, by Doctor A, who made an appointment for the scan to be completed at Lagan Valley Hospital. Documents show that the appointment had been cancelled by the Radiology Department at Lagan Valley Hospital, 17 May 2017, as it did not meet local guidelines.

The Clinical Reviewer, Ms MacKenzie, considered the possibility that Mr Stewart's concerns about his mouth could have arisen for mental health reasons. This is particularly pertinent given the concerns Mr Stewart's family have about his state of mind and the question they raised about his mental wellbeing. It is, therefore, appropriate to quote directly from Ms Mackenzie's report:

[7] An Orthopanthomogram is a panoramic dental x-ray

> "The question of whether Mr Stewart's problems with the foul smell and taste in his mouth was based on a psychological or mental health reason can now only be speculative. However the care and treatment he was receiving for his reported problem was appropriate within the short time he was at Maghaberry and in time, perhaps further tests and assessments may have eliminated any physical cause and steered clinicians in a different direction."

In other words, more time would have been needed for a full conclusion to have been reached regarding a mental health source of Mr Stewart's oral issues. This is important given my responsibility to consider whether or not the care Mr Stewart received was appropriate. Dental appointments took place without any delay. His first dental appointment was within 4 days which compares significantly favourably with community waiting times which were 3 to 4 weeks, if prompt, in 2017. Given prompt appointments and that a second opinion was provided quickly, I am satisfied that there was no delay in responding to Mr Stewart's needs I concur with Ms Mackenzie's findings that his death could not, on the balance of probability, have been predicted or prevented.[8]

6.3 Family questions

1.	Is there any evidence that Mr Stewart was in a psychotic state?
Mr Stewart's Initial Mental Health Screen was completed appropriately with no further review required. There is no record of him raising any issue about, or of any issue being raised about, his mental health. The Clinical Reviewer considered the possibility that Mr Stewart's concerns about his mouth could have been evidence of a deeper problem and is clear that they may have been but to assess this fully a process of elimination would have had to have been followed to rule out physical sources of the problem. That process could be considered to be underway. I am aware that some family members believe mental ill-health could have been the cause of Mr Stewart's concerns. However, on available evidence it is not possible to conclude he was in a psychotic state.	
2.	**Was Mr Stewart able to access medical assistance when he requested it?**
Dental: Mr Stewart requested to see a dentist when he was admitted into custody, 15 March 2017. He had his first dental appointment on 20 March 2017 and a review on 12 April 2017 at which the dentist asked for a second opinion. Another dentist saw Mr Stewart on 11 May 2017. He also saw a nurse on 09 May 2017 because he had toothache.	

[8] The Clinical Reviewer said: "Having reviewed all of the information available, it must be concluded that on the balance of probability Mr Stewart's death could not have been predicted or prevented."

Nurses and GP: Mr Stewart had 2 appointments with a nurse at committal and another nurse appropriately carried out the Initial Mental Health Screen. On 23 March 2017 he saw a nurse in relation to his dry skin and was advised that if things did not improve he could be referred to a GP. He returned to the same nurse on 30 March 2017 and was referred to a GP whom he saw on 26 April 2017. He also saw a nurse on 09 May 2017 and was given paracetamol for his toothache.

At interview some of those in custody with Mr Stewart speculated about what might have influenced him to self-harm. They mentioned a perceived lack of response to his requests for medical help in the days before his death. There are no records of any requests for medical help, including mental health support, beyond those reported here. Those reported here were followed up in a timely and effective way. (This includes the external appointment at Lagan Valley Hospital for an OPG)

Section 7: Events post-incident

7.1 The importance of post-incident responses

When an individual in custody is found unresponsive follow-up actions are critical to ensure that a scene is properly preserved and examined, that investigators are informed and given access to the scene and that the family are informed in as timely a way as possible. This section will consider responses by both Prison Service and Trust Staff and include how support is provided to those within the prison setting who are impacted by events such as this. Mr Stewart's family have a number of ongoing concerns and have commissioned reports. I will consider these concerns and reports within this section and will address the following questions asked by the family:

- Why was Mr Stewart Senior not informed more promptly about the incident on 17 May 2017 and why was he informed by telephone?
- Should there be a recommendation about post-incident support for individuals in custody?

7.2 Immediate incident responses

When Mr Stewart was found unresponsive the alarm was raised quickly and nurses were promptly on the scene. Prison Service staff had commenced cardio pulmonary resuscitation (CPR) in line with procedure and Trust staff continued CPR until paramedics arrived.

The Clinical Reviewer, Ms MacKenzie, reviewed actions of Trust staff and was satisfied that the response and treatment were prompt and professional in what were difficult and challenging circumstances. Ms MacKenzie said it was evident to her that both

Trust and Prison staff did all they could to save Mr Stewart's life and she commended their efforts, a commendation with which I concur.

Ms MacKenzie identified a number of learning points for future practice but said that these did not impact on efforts to resuscitate Mr Stewart. I will address learning about use of Code Red and Code Blue calls, staff training and CPR in Part B of this Report.

7.3 Notification of Mr Stewart's Family

At 06:31 on 17 May 2017 the Duty Governor, Governor A, telephoned Mr Stewart's father to inform him of his son's death. Mr Stewart Snr did not initially answer the call and a message was left on his phone to ring the prison. Mr Stewart rang the prison 6 minutes later at 06:37 and Governor A informed him that his son had died. At the initial family meeting the family queried the length of time taken to notify them and why they had been informed by telephone.

Prison Service procedures to be followed when a death occurs set out guidance on contacting next of kin in the event of a death in custody. Guidance is that the Governor in charge or Duty Governor must inform, as a matter of urgency, the immediate family or next of kin or arrange for another appropriate person to do so. The policy also provides for the Governor to arrange for a family chaplain or local PSNI officer to inform the next of kin should the Governor deem that to be more appropriate.

When a death occurs in prison, the Police Forensic Medical Officer (FMO) will usually confirm the death prior to next of kin being notified. In this instance an FMO had not attended the prison when the Duty Governor took the decision to notify the next of kin. This was a reasonable decision given that paramedics had recognised life extinct and the Governor was concerned to get the information to the family. Given the passage of time, there was a risk of the family hearing the news from a third party, social media or other media. Following consultation with senior on-call Governors, at Maghaberry Prison and Prison Service Headquarters, Governor A contacted Mr Stewart. The FMO did not attend the prison until 08:23 that would have resulted in a lengthier delay in notifying the family. In my view, Governor A, made the right decision to proceed to inform Mr Stewart's family. I have some sympathy with the family on this matter. From their point of view some hours had passed by the time they heard the news. In reality, the Governor took a decision to inform them some 2 hours before the FMO attended the scene and the delay, if procedures had been tightly adhered to, would have been much longer.

7.4 Search of Mr Stewart's cell and the scene generally

The PSNI were notified of Mr Stewart's death at 03:35 and they telephoned the prison, at 03:45, to request that the scene was preserved pending their arrival. Guidance states that during the night it is the responsibility of the Night Senior Officer to ensure the scene remains isolated with the exception of essential medical

personnel. Senior Officer A confirmed this was done once paramedics recognised life extinct. A follow-up call was made to the PSNI at 04:15 to request an update on their estimated time of arrival. Police Officers arrived in Lagan House at 04:44 to commence their investigation on behalf of the Coroner.

The police searched the cell after all forensic examinations by the Crime Scene Investigator had been completed. The Crime Scene Investigation Record notes that the remains of a broken Mach 3 razor head were found in the bin, blades had been removed from the razor head and two blades were missing. The report goes on to say that as the cell floor was heavily bloodstained, the Officer was unable to locate further blades from the razor at that stage. The PSNI Investigating Officer recorded that a search was conducted of the cell for any blades or sharp objects but nothing was found. One of the challenges to searches was the amount of blood at the scene which presented health and safety concerns for searchers and restricted what physical searches could be done. The rest of the cell was searched and an itinerary of the contents was recorded by the PSNI. These matters are considered by Independent Reviewers appointed by the family who feel strongly that other means of searching could have been deployed.

The absence of the two missing blades, assumed by the PSNI to have inflicted Mr Stewart's wounds, has added to the family's distress causing them to question whether his death was self-inflicted. The PSNI Investigating Officer was satisfied Mr Stewart's death was self-inflicted. Dr Helen Davey, appointed by the family to review materials relating to the incident, concluded that appropriate steps appear to have been taken by the PSNI to treat and preserve the scene. She also concluded that:

> "... if one or two of the blades had been used in isolation, then I am of the opinion that the level of search we know about could have meant that the blades could have been within bloodstaining, or for example, have gone down the plughole and not been found."

However, she did note a lack of clarity in investigative notes with regard to the level of searching. This is not a matter I can consider as it is not within the scope of my remit.

No suicide note was found in Mr Stewart's cell although there were 2 torn up letters in the bin which had been written on prison issue paper, both to Mr Stewart's partner following their visit on the morning of 16 May 2017. The content of each letter was very similar and neither appears to have been finished. In these letters Mr Stewart thanked his partner for coming to see him and for bringing him trainers and socks. In one he specifically mentioned her being 'there' for him. He asked his partner to let his Dad know that another individual in custody who knew the family sent his

regards. He finished the other letter by writing, 'Thanks for everything thanks for being here' and saying he was glad all was okay there.

The PSNI found several other notes in Mr Stewart's cell and they recovered 3 notes from a locked medication box. The family examined them and recognised similarities to Mr Stewart's handwriting but were at a loss to explain the religious verses these notes contained as they did not think Mr Stewart was religious.

The content of one note seemed to have a direct link to Mr Stewart as it referenced someone whose name was the same as that of a family member. It is not possible to say conclusively whether Mr Stewart wrote the notes that were found in the locked medication box as I could not be establish whether he was issued with a key to the box and no key was found in his cell. There was only one Cell Compact on Mr Stewart's residential file which related to a cell in Bann House. The Compact was signed by the person in custody to acknowledge the integrity of the physical structure of the cell and to record if a key to the medication box has been issued. As this form was not completed for his cell in Lagan House, I cannot establish if Mr Stewart had access to the medication box. The Prison Service clarified that a Cell Compact should be completed for each cell move.

The matter of whether a Cell Compact was completed in this case is not directly relevant to Mr Stewart's death. However, in instances where there might be an issue about abuse of medication it would be important for the Prison Service to be able to establish whether the individual in custody had received a key and this would be recorded on the Cell Compact, now held electronically. I have repeatedly made recommendations about recording information. The pandemic has provided the Prison Service the opportunity to install more digital recording mechanisms which should improve record keeping. I will continue to monitor this improvement. In a pre-pandemic setting I would have recommended a reminder be provided to staff about completing the Cell Compact but in the current context this is no longer appropriate.

There is no doubt that when someone dies in custody there are impacts on all who have known the individual and this can be compounded by the circumstances of the death. In Mr Stewart's case, when Prison Officers opened his cell they were presented with a difficult scene. There was considerable blood already on the floor and Mr Stewart had to be moved out of the cell in order for CPR to begin. Inevitably there was disturbance of the scene with Prison Officers, Trust staff and paramedics attending to Mr Stewart. When paramedics recognised that life was extinct the immediate concern of the Prison Service was to secure the scene until the PSNI arrived. Procedures are set out which are critical to ensuring the integrity of evidence. Mr Stewart's family raised a concern about a sheet that was placed over his body. It is not normal practice for the Prison Service to cover the deceased in this way but it would appear that in this case someone did place the sheet over Mr Stewart. As Mr Stewart had been moved onto the landing and as there are a lot of people coming

and going on a landing when someone dies, whoever placed the sheet did so as an act of respect. While this is understandable, it presents some difficulty to the family. While I agree there is a concern, I also note that the scene was already significantly disturbed due to necessary medical interventions and moving Mr Stewart onto the landing to allow these to proceed. Nevertheless, given the concern I am recommending that the Prison Service review written procedures and provide a training update to those responsible for the scene of a death in custody:

The family also wanted to know about a chair that can be seen in photographs, sitting on the landing. The chair would normally have been inside Mr Stewart's cell. I cannot definitively provide them with information about how the chair was moved. It is within the bounds of possibility that it was moved when Mr Stewart was found, to provide room for those providing medical intervention to work. Other individuals in custody spoke to my Investigation Officer about hearing noises such as furniture moving.

It is unclear when the chair was moved and who placed the sheet over Mr Stewart. For the family the concern is that some significant evidence has been lost or removed. My remit is to examine the processes followed by the Prison Service to ensure they were to standard. It is my belief that the sheet was placed over Mr Stewart out of respect for him as there was significant movement of personnel on the landing following his death. However, the concerns raised by Mr Stewart's family are real and I therefore make a recommendation to reflect the need to preserve the scene.

Recommendation 2: Preserving the scene of death in custody

The Prison Service should complete a review of procedures for preserving the scene of a death in custody, update them where required to ensure robust protection of the scene and communicate any changes to procedures to relevant staff and managers and provide my Office with an update when this has been completed.

7.5 Post-incident support

Prison Service Standards set out that Hot and Cold Debriefs must take place following a serious incident of self-harm or death in custody. The Hot Debrief should take place as soon after the incident as possible and include all staff closely involved with the incident. The purpose of the Hot Debrief is set out: to provide staff with an opportunity to express any view they have in relation to how the incident was discovered and managed and to address any additional support or learning needs

staff may have. The Cold Debrief should take place within 14 days of the incident and aims to provide further opportunity for staff to reflect on events and identify any additional learning.

Following Mr Stewart's death, the Hot Debrief took place at 07:45 on 17 May 2017 and was chaired by the Deputy Governor, Governor C. Staff directly involved in the incident attended the Debrief. Everyone was asked to give an account of the incident, how they responded and what relevant information they knew at that time. Governor C instructed that the AED was replaced in Lagan house and made all attendees aware of staff support services.

The Cold Debrief took place on 01 June 2017 and was again chaired by Governor C. It was attended by most of the Prison Service staff directly involved in the incident. The Prison Officers' Association, IMB, PSST and PRRT were also represented.

The meeting reviewed events, how staff responded and subsequent action to support Prison Service staff. It was noted that PRRT would provide psychological first aid to those affected by the death and that this type of support would usually be provided within 72 hours of an incident. No follow up actions in response to the incident were identified.

Directly after the Cold Debrief PRRT ran a psychological first aid session and this was particularly well received by the Prison Service staff who attended. There was a broader discussion at the Cold Debrief about the fact that the last 2 deaths in custody were of people who had not been identified as posing an imminent risk of suicide and consequently were not being managed under the prison's SPAR arrangements at the time.

One of the Prison Officers suggested that consideration might be given to placing people on SPARs in the same location as it was difficult to manage 15-minute observations when those on SPARs were accommodated on different Landings. He also highlighted to this investigation that it was challenging to ensure appropriate SPAR observation checks were conducted when other night custody responsibilities also had to be fulfilled.

There was a suggestion to reopen 2 Landings in Bann House, though the potential difficulty of managing people in observation cells in conjunction with new committals was a counteracting factor. Governor C acknowledged the challenges identified by staff and referred to limitations in the then current process.

Many of these concerns have been addressed by the introduction of a new SPAR approach which built on learning from the SPAR approach in place when Mr Stewart died. 'SPAR Evolution' has been tested across all prisons since late 2018 and is being reviewed for further learning. I have asked the Prison Service to share the review with my Office and look forward to considering any learning or improvement identified.

The Landing Journal records that 2 Listeners[9] were made available to those in custody on the afternoon of the 17 May 2017 and that 2 members of the Mental Health team were also available on the Landing. Confidential support for individuals in custody is important. All those in custody are also aware of the Samaritans Phone which is available to them and Prison Officers take care to ensure anyone wanting to use that telephone, which is a Freephone service, can do so.

7.6 Family Questions

1.	**Why was Mr Stewart Senior not informed more promptly about the incident and why was he informed by telephone?**
Prison Service policy is in place to ensure families are contacted in as timely a manner as possible. Contact was made in line with Policy and discretion was applied appropriately to contact the family as quickly as possible.	
2.	**Should there be a recommendation about post-incident support for prisoners?**
In a letter from their solicitor, January 2022, Mr Stewart's family expressed a concern that a recommendation was made about supporting Prison Officers following incidents such as this but there was no recommendation about support for individuals in custody impacted by events. This is a matter which I have taken an interest in during my appointment and I am aware that individuals in custody are provided with information about bereavement support. It is important to remember that those in custody share a living space and become friends with one another. Events such as this one can cause traumatic reactions. The fact that 2 Samaritan-trained Listeners and 2 of the Mental Health Team were available on the Landing on the afternoon following the incident is evidence of the care the Prison Service have taken to ensure support for those living alongside Mr Stewart. I do not believe that a recommendation is required given the support that was provided.	

[9] Listeners are trained by the Samaritans to listen to others in custody who may be finding life challenging and need a confidential outlet for their concerns. Listeners receive ongoing support and training from the Samaritans

Section 8: Family concerns and their commissioned reports

8.1 Information considered in my investigation

While it is the Coroner's task to establish cause of death, post-mortem reports can provide useful insights for examination of the circumstances and events surrounding a death in custody. In this instance the family commissioned 2 further reports.[10] In this section I will draw on some information from these reports and also from the additional post-mortem report[11], to respond to the following questions raised by the family:

- If Mr Stewart had self-harmed, would there have been cuts on his fingers?
- Where were the missing blades which Mr Stewart may have used to harm himself?
- What is the timeline of communications from the PSNI?
- Was the cell checked for DNA?
- Did Mr Stewart have drugs in his system when he died?
- Why was there blood on the cell bell?

I am conscious that a considerable amount of information contained in these family commissioned reports relate to the PSNI. I must ensure that I do not overstep my remit and will focus only on the actions of the Prison Service.

8.2 The post-mortem report

The post-mortem report records the cause of Mr Stewart's death as an 'Incised Wound to the Neck' and also noted injuries to his left arm. Dr Gray was commissioned by Mr Stewart's family to comment on cause of death taking account of medical, pathological and toxicological evidence. It is not within my remit to discuss cause of death but for the purpose of completeness and confidence in the post-mortem report I quote Dr Gray[12]:

[10] Independently commissioned report from Dr Helen Davey, forensic scientist, dated 16 June 2021 and received by my Office on 24 January 2022; Independently commissioned report from Dr Carl Gray, forensic pathologist, dated 1 June 2021 and superseded by a broader report of 26 August 2021 which was received by my Office on 24 January 2022

[11] Dr Christopher Johnson's Pathology Report dated 05 September 2017 and received by my Office on 13 October 2017

[12] Report of Dr Gray, pages 12f

> "The post mortem report is detailed and reasonable. There is no reason to doubt any of the stated observations……I agree with the overall conclusions of Dr Johnston."

The principal injury was a cut to Mr Stewart's left internal jugular vein which accounted for the large amount of blood at the scene. Dr Johnson commented that the characteristics of the wounds to Mr Stewart's body were typical of being self-inflicted and that a razor blade was capable of producing these wounds. No blade was found at the scene. Dr Gray concluded that, 'injuries could possibly have been inflicted by a detached razor blade,' and that, 'wounds were consistent with self-infliction.' Dr Gray further concluded that, 'The absence of wounds to the hands does not exclude the other conclusions.'[13]

8.3 The missing blade(s)

The matter of the blade, suggested as the most likely cause of the fatal injury, has been of some concern to Mr Stewart's family as not all 3 Mach blades from Mr Stewart's razor were located after his death. There is no conflict between the 3 additional reports as to the possibility that a razor blade could have caused the fatal injuries.[14] This is ultimately a matter for the Coroner.

Dr Davey addressed the matter of the blade and described how blades can be formed together into a weapon. She concluded that if blades had been fashioned together into a weapon there would have been more likelihood of such a weapon being located post-incident, during searches of Mr Stewart's cell. I have referenced this in Section 7.4 of my report. All 3 agree that the wounds on Mr Stewart's neck were compatible with a blade and with self-infliction.

8.4 The possibility of third-party involvement

Given that a blade potentially responsible for the injury has not been located it has been important for the family that consideration be given to the potential of third-party involvement in Mr Stewart's death. Dr Davey specifically addressed this matter through examination of the scene, blood distribution and spatter. It is not for me to make a finding on this matter but it is helpful to include Dr Davey's conclusions. She cited the lack of blood trace on the door or on the floor leaving the cell, which suggested, in her view, any third-party involvement to be unlikely[15]:

[13] Report of Dr Gray, page 17
[14] "The circumstantial evidence reported offers only the possibility of a razor blade with no other possible weapon found in the closed cell." Report of Dr Gray, page 13
[15] Report of Dr Helen Davey, page 20

Dr Gray specifically addressed the matter of wounds to Mr Stewart's hands which it might be expected would have been evident from using a small blade. He concluded[16]:

> "When considering the possibility of third part involvement, I am of the opinion that the lack of any disturbance to items on the surfaces in the cell, many of which would be easily toppled if furniture was knocked, suggests there had not been a significant struggle in the cell... The absence of injuries to the hands does not exclude the possibility of an assault by another person or self-infliction of other wounds by blade held in the hand."

Dr Davey concluded that cell scene photographs and blood patterns corroborated Prison Officers' accounts of how Mr Stewart was found and how he was moved onto the landing for CPR.

8.5 Blood on the cell bell

Dr Davey considered how a blood mark could have been made on a black panel which is the site of the light switch and cell bell. She described the panel as being behind the toilet, framed by Perspex and housing a metal switch and a circular metal button for the light and the bell respectively. She noted 'light contact bloodstaining on the lower right quadrant of the Perspex,'[17] extending onto the light switch. She concluded it was likely someone with blood on their hand had made contact with the panel and that this was compatible with someone reaching across from the basin area. Given that Mr Stewart was likely to have been capable of movement for some minutes after the wound was inflicted he could have touched various surfaces, including the black panel.

8.6 The Trust Serious Incident Review

The Trust completed their Review on 23 August 2017. The fact that Mr Stewart was not known to the Mental Health Team was noted along with the fact that triggers and factors for self-harm had not been identified. Assessments were reviewed to ensure they were completed robustly and no concerns were noted.

A number of areas of good practice were noted and I will mention these in Section 9.

[16] Report of Dr Gray, page 15

[17] Report of Dr Davey, page 12

8.7 Family questions

1.	**Questions about Mr Stewart: If Mr Stewart had self-harmed would there have been cuts on his fingers? Did Mr Stewart have drugs in his system when he died?**

Dr Gray examined this matter and stated that the lack of cuts on Mr Stewart's fingers was not inconsistent with self-inflicted wounds.

Dr Johnson's report stated there was no evidence of drugs or alcohol in Mr Stewart's system at the time the autopsy was completed on 18 May 2017.

2.	**Where are the missing blades which Mr Stewart may have used to self-harm?**

Mr Stewart had access to Gillette Mach 3 razor blades via the tuckshop. On 23 March 2017 he ordered a Gillette Mach 3 razor and blades. As referenced above, records of searches note that:

- 2 blades were missing from the razor head
- the cell was searched by CSI and PSNI detectives
- there was heavy bloodstaining on the floor, including biohazard material which was not searched for reasons of safety.

Undoubtedly the lack of discovery of a blade or blades has added to family concerns about the veracity of information. However, in reports from Dr Johnson, Dr Davey and Dr Gray, the likelihood of Mr Stewart's injury being caused by a blade is noted.

3.	**Questions about cell searching after Mr Stewart's death: Was the cell checked for DNA? What is the timeline of communications from the PSNI?**

In her report, Dr Davey notes that appropriate steps appear to have been taken in respect of scene protection and preservation. She recounts searches of the cell and records relating to those searches and provides comment on what she considers to be 'possible limitations in the investigation' which she considers pertinent[18]:

- "The level of searching of the cell carried out by 3 different individuals is not clear from their statements;
- The absence of a record detailing whether the blade recovered from the bin was blood stained."

[18] Report provided by Dr Helen Davey, page 22

<table>
<tr><td colspan="2">It appears evident that coagulated blood was not fully examined due to health and safety risks. The degree to which this impacts conclusions is a matter for the Coroner at inquest. The timeline of communications from the PSNI is set out in Section 5:</td></tr>
<tr><td>03:35</td><td>PSNI informed about Mr Stewart's death</td></tr>
<tr><td>03:45</td><td>PSNI telephoned the prison requesting the scene be preserved</td></tr>
<tr><td>04:15</td><td>Prison contacted the PSNI to request time of attendance</td></tr>
<tr><td>04:44</td><td>PSNI arrived at Lagan House</td></tr>
<tr><td>4.</td><td>Why was there blood on the cell bell?</td></tr>
<tr><td colspan="2">Dr Davey specifically examined blood patterns at the scene. She noted blood on the black panel where the cell bell is located and noted that the mark was consistent with someone reaching for the panel containing the light switch and cell bell.</td></tr>
</table>

PART B: LEARNING AND GOOD PRACTICE

Section 9. Learning for Improvement

9.1 The importance of learning

One of the purposes of my investigations is to ensure learning from past experience to improve practice in the future, including identifying existing good practice to ensure it continues into the future. Such learning should enhance procedures and the experience of those involved with a death in custody.

The Clinical Reviewer, Ms MacKenzie, identified several learning points. These have been raised previously and the Prison Service and Trust have responded positively and taken action. I do not believe these learning points affected Mr Stewart's unexpected death.

9.2 Code Red and Code Blue calls

Ms MacKenzie addressed the decision to make a Code Red call when Mr Stewart was discovered. This was entirely understandable in the circumstances as a Code Red call is made when there is severe bleeding, as in this case. However, given that Mr Stewart was also unresponsive a Code Blue[19] may have been a more helpful call. It is highly unlikely that the type of Call made had any impact on Mr Stewart's care but it is possible that in some future circumstance it could make a difference. Ms MacKenzie therefore recommended that clearer guidance could be issued to staff to the effect that should assessment following a Code Red call require it, then a second call could be activated. It would also be helpful for staff to have a clear Prison Service definition of Code Red and Code Blue call messages. The Trust has added questions to be asked when an emergency call is made to help assess the situation:

- Is the person responding/talking?
- Is the person breathing?
- Has an ambulance been called?

Further information can then be requested if clarifications are required.

Ms MacKenzie recommended that the Prison Service should review the Code Red and Code Blue emergency call out procedure. A separate clinical reviewer in another

[19] Code Blue is an emergency call out within the prison and defined in the Emergency Procedures. It is the code used when an individual in custody is found with symptoms of severe chest pain, difficulty in breathing, cannot complete sentences, is unresponsive to voice, is fitting or had a seizure, or attempted self-harm by use of a ligature.

investigation made the same recommendation. The Prison Service accepted the recommendation and in April 2018 new guidance on the use of emergency codes was issued at Maghaberry Prison. This matter has, therefore, been addressed and no recommendation is required.

9.3 CPR

The Clinical Reviewer noted that some Prison Service staff had received a basic introduction to CPR as part of an emergency first aid course during their induction training. Some of those staff said they would feel more competent using CPR if there were regular updates or training that is more intensive. Their level of training is within the Resuscitation guidelines for 'regular' updates and I also note that I have made a recommendations about training in other reports and these have been accepted and implemented.

I am not making a recommendation in this instance for 2 reasons:

a. All new recruits receive emergency first aid training to ensure they can carry out CPR and use the defibrillator

b. While there is no refresher training currently in place a new Learning & Development Manager has been appointed and will assess the need for refresher training based on job role and ensure that training is delivered.

Both Nurses involved in resuscitation had completed Intermediate Life Support (ILS) training in 2015, 1 had not completed the annual refresher training in 2016. Due to a break in employment, it could not be established if the other Nurse had completed the annual refresher training. Ms MacKenzie was satisfied that the resuscitation was conducted in line with National Guidelines but she recommended that training to maintain knowledge and skills should be provided in accordance with the Trust's stated aim that Healthcare in Prisons staff acquire ILS recertification training every 2 years, with BLS training completed in the intervening years. I agree with Ms MacKenzie and recommend that:

Recommendation 3: Life Support

The Trust (Healthcare in Prison Service Managers) should ensure that staff training and refreshers are up to date and in line with *Resuscitation Council UK Quality Standards for CPR Practice and Training* (May 2017) and Trust Policy.

Ms MacKenzie also noted that a question was raised about the decision to commence CPR when there is a total absence of life signs and the person has probably been dead for some time and she commented:

> "While it is recognised how difficult and traumatic performing CPR can be in some circumstances and there are times when it may seem futile, or for the persons dignity it may seem inappropriate to continue, it is only doctors, paramedics and those nurses who have attained a level of training that enables them to make an assessment and judgement as to whether CPR should be commenced or discontinued, can make this decision (unless there is a pre-planned decision by a clinical team not to resuscitate). The above should be covered in a local policy or clear guidelines (if not already) that reflects the Resuscitation Council UK Guidelines (2015)."

A different Clinical Reviewer, in another investigation, made the same recommendation for local policy or clear guidelines that reflects the Resuscitation Council UK Guidelines. The Trust accepted this recommendation and advised it was being progressed and therefore the recommendation is not repeated in this report. The Clinical Reviewer suggested that the joint National Offender Management Service, Royal College of Nursing and Royal College of General Practitioners Guidance to support decision making about when not to perform CPR in prisons and immigration removal centre (IRC) was a useful reference document.

9.4 Post incident support

Ms MacKenzie considered the post incident debrief meetings and highlighted these as notable practice. She observed that the meetings were held within the appropriate timescales and those attending found them helpful and supportive. Ms MacKenzie noted signposting to *Carecall* (now *Inspire*[20]), staff welfare and excellent resource provided by PRRT. A PRRT representative attended the Cold Debrief meeting and informed staff about their role. She noted concern that Trust Staff did not attend the Cold Debrief. The Trust advised that *Inspire* is available to their staff. Ms MacKenzie commented:

> "Clearly there are support mechanisms in place following an incident and managers have been commended on this, however there does not seem to be any systematic follow up as to whether prison and healthcare staff have the ongoing support they need following a traumatic event and some staff some months after Mr Stewart's death felt they were expected to cope, because that's what they do."

[20] Inspire provides confidential counselling services.

Given that effective interventions can be made to support those experiencing reactions to traumatic and stressful events, I am pleased to note that The Prison Service completed peer mentor training to provide support to those who have experienced challenging circumstances. This piece of work involves debriefing and supporting operational staff involved in critical incident work. Both immediate and ongoing support is provided.

The Minister of Justice commissioned a review into support services for operational Prison Service staff, published in January 2021. The Prison Service continues work to implement the over 60 recommendations which includes the *Critical Incident Stress Management Programme*. I welcome their approach to this important work and encourage them to maintain their efforts in this respect.

Both the Healthcare in Prison Team and the wider Trust provides support for staff involved in any serious adverse incident, both during and outside normal office hours. All Healthcare in Prison staff involved in such incidents are made aware of these support services. A new written procedure has been devised and implemented: *Procedure for staff / patient support following a death in custody*. This includes offering reflective support sessions which can be held in groups or individually depending on what staff request.

Although not specifically mentioned at the Debrief meetings a number of those in custody who were interviewed for this investigation acknowledged the role of the Nurses and members of the Mental Health Team in providing support on the Landing immediately after Mr Stewart's death.

9.5 Good practice

I note some matters of good practice for future reference:

- Healthcare assessments were completed within timescales
- The responsiveness particularly of dental healthcare for Mr Stewart but also of nursing and GP responses
- Staff engagement with Mr Stewart on the landings, especially to reassure him regarding his dental and mouth concerns
- The speed and efficiency of staff attending the scene of Mr Stewart's death both in accessing the cell and providing care to Mr Stewart.
- Hot and Cold Debriefs were completed within timescales, information was provided regarding Inspire services and the attendance of PRRT at the debrief
- Provision of support to individuals in custody, including Listeners and the Mental Health Team on the landing on the day of Mr Stewart's death.

Ms MacKenzie noted, regarding Trust Staff:

> ".. their care and treatment of Mr Stewart was based on evidence and best practice and their actions were fully compliant with local, national and professional policies and guidelines and their level of training."

Section 10: Conclusions

Mr Stewart's family have expressed a number of additional concerns. I have communicated directly with them on some of these matters, including:

a. That publication of my report may prejudice the jury at inquest. I work closely with the Coroner to ensure reports are published in a timely and appropriate manner. In respect of this concern, it is for the Coroner to address this matter when a jury is being appointed.

b. Was the testimony of other individuals in custody taken fully into account? Throughout this report accounts are provided of witness information. Where that information conflicts with other information I have demonstrated this in the text. Individuals in custody are informed of my investigation and can come forward for interview. A number were interviewed in the course of this investigation. Some had been released and where possible my Investigating Officer followed up with them to see if an interview could be arranged. Some could not be located or did not respond to my correspondence.

c. The family hold the view that my report relies on speculation rather than being based in fact. It is important that my report presents what can be corroborated and where there is conflicting information. I have set out the evidence examined during the course of investigation, those who were interviewed and other sources of information and evidence. I consider my report to be based in fact.

The scope and remit of this investigation was set out in Section 3.4 of this report:

Provide a timeline of events leading up to Mr Stewart's death;
I have established, from written records and statements, a chronology of events leading up to Mr Stewart's death on 17 May 2017. The timeline is reflected throughout my report and can be found at Appendix 5.
Establish the circumstances and events surrounding Mr Stewart's death and as far as possible provide explanations and insight for Mr Stewart's family;
The narrative of events and information about medical and other appointments, accounts of Mr Stewart's engagement with family, others in custody and staff, his cell moves, property and participation in activities are intended to provide explanations and insight as far as that is possible. I have also endeavoured to address each of the questions Mr Stewart's family have raised with me.
Examine whether Mr Stewart's health care and mental health needs were appropriately managed in prison, including whether any potential signs were missed which could have predicted or prevented Mr Stewart's death
I concur with the Independent Clinical Reviewer, that Mr Stewart's health care and mental health needs were managed appropriately and that there were no signs missed which could have predicted or prevented his death. In particular, the dental care that Mr Stewart received was prompt, likely more prompt that it would have been in the community. It may well have been the case that Mr Stewart's dental problems to be indicative of another problem. Sadly, there was not enough time for explorations to reach a conclusion or to point to any underlying mental health concerns.
Establish any learning from events around Mr Stewart's death and identify good practice
This is noted in Section 9.
Assist the Coroner's inquest in achieving fulfilment of the investigative obligation arising under Article 2 of the European Convention on Human Rights, by ensuring as far as possible that the full facts are brought to light

and any relevant failing is exposed, any commendable action or practice is identified, and any lessons from the death are learned.
My office will make full disclosure of materials to the Coroner.

Appendix 1: Terms of Reference for Prisoner Ombudsman investigations into Deaths in Custody

1. The Prisoner Ombudsman will investigate the circumstances of the deaths of the following categories of person:
   - Prisoners (including persons held in young offender institutions). This includes persons temporarily absent from the establishment but still in custody (for example, under escort, at court or in hospital). It excludes persons released from custody, whether temporarily or permanently.

     However, the Ombudsman will have discretion to investigate, to the extent appropriate, cases that raise issues about the care provided by the prison.
2. The Ombudsman will act on notification of a death from the Prison Service.

   The Ombudsman will decide on the extent of investigation required depending on the circumstances of the death. For the purposes of the investigation, the Ombudsman's remit will include all relevant matters for which the Prison Service, is responsible, or would be responsible if not contracted for elsewhere. It will therefore include services commissioned by the Prison Service from outside the public sector.
3. The aims of the Ombudsman's investigation will be to:
   - Establish the circumstances and events surrounding the death, especially as regards management of the individual, but including relevant outside factors
   - Examine whether any change in operational methods, policy, and practice or management arrangements would help prevent a recurrence
   - In conjunction with the (DHSS & PS) replaced with South Eastern Health and Social Care Trust as the healthcare provider in prisons, where appropriate, examine relevant health issues and assess clinical care
   - Provide explanations and insight for the bereaved relatives.
   - Assist the Coroner's inquest in achieving fulfilment of the investigative obligation arising under article 2 of the European Convention on Human Rights, by ensuring as far as possible that the full facts are brought to light and any relevant failing is exposed, any commendable action or practice is identified, and any lessons from the death are learned.
4. Within this framework, the Ombudsman will set terms of reference for each investigation, which may vary according to the circumstances of the case, and

may include other deaths of the categories of person specified in paragraph 1 where a common factor is suggested.

Appendix 2: Terms of Reference for a clinical review of healthcare in the case of Mr Jonathan Stewart

To review the medical and healthcare records of Mr Jonathan Stewart, to produce a report giving an expert opinion and advice regarding:

- Mr Stewart's health care and mental health needs and how they were managed, including if there were any risks that could have been identified;
- The Cardio Pulmonary Resuscitation provided to Mr Stewart;
- Any learning points for the Northern Ireland Prison Service (the Prison Service) and the South Eastern Health and Social Care Trust (the Trust).

Appendix 3: Questions raised by Mr Stewart's Family

Accommodation, Property and care by the Prison Service

- Why was Jonathan moved from Quoile House where he was happy to Lagan House where he was not? The family have a perception that a lot of drugs were available in Lagan house and therefore it was not appropriate for an addict to be housed there;
- Had Jonathan any contact with chaplaincy support at Maghaberry Prison?
- Jonathan had made a number of requests for phone access to contact family members. Were these dealt with appropriately by the Prison Service?
- Was Jonathan able to access medical assistance when requested it?
- Why did Jonathan have blades in his cell?

Specifically relating to Mr Stewart's death on 17 May 2017 and responses to him being found in his cell:

- Where are the missing blades which Jonathan may have used to self-harm?
- What is the timeline of communications from the PSNI? The family are distressed by the thought that Jonathan may have been murdered;
- Three notes were found in Jonathan's cell. Were they written by Jonathan? Where were they found? Where are they now?
- If Jonathan had self-harmed would there have been cuts on his fingers?
- Was the cell checked for DNA?
- Did Jonathan have drugs in his system when he died?
- What changed from the visit on 16 May 2017 when Jonathan appeared fine that could have caused him to self-harm later that night?
- Is there any evidence that Jonathan was in a psychotic state?
- What time did Jonathan die?
- Why Mr Stewart (senior) was not informed until 08.00 on 17 May 2017?
- Why Mr Stewart (senior) was informed by the Governor, by phone?

- Jonathan had a diary in his cell with unknown numbers in it. To whom did the numbers belong?
- Had the emergency cell bell been tested on 16 May 2017 and why was there blood on it after Jonathan's death?
- Was it appropriate for the cell door to be opened by an unaccompanied Prison Officer?

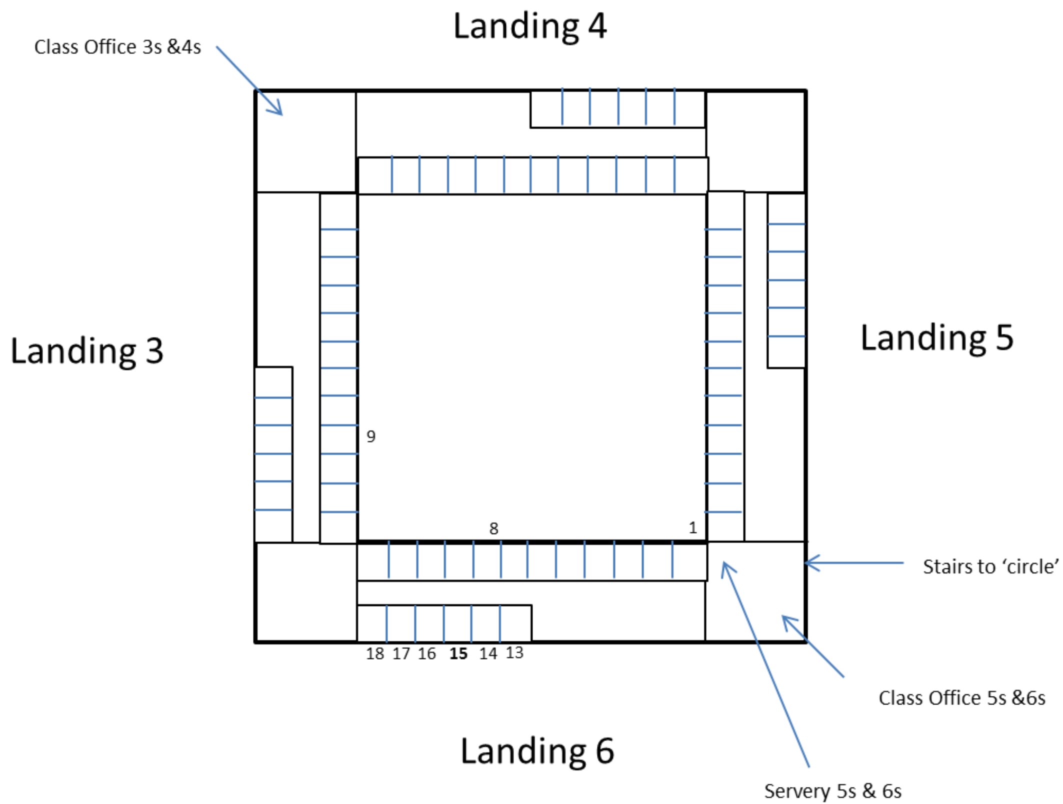
Questions relating to my investigation submitted February 2022:

- Publication of my report may prejudice the jury at inquest;

Queries raised by the family that have not been addressed. Specifically:

- There is a recommendation for post-incident support to staff but not for prisoners. Should such a recommendation be included?
- The prisons Internal Complaints Process suggests a prisoner had not heard Jonathan when he had and there is no recommendation
- There was no CCTV available in Lagan House. Should a recommendation not be made as it would answer some questions?
- Was the testimony of other prisoners fully taken into account?
- The family hold the view that my report relies on speculation rather than being based in fact. Is this the case?

Appendix 4: Diagram showing the layout of the upper floors of Lagan House



(This diagram is not drawn to scale nor is it an exact representation of all features of the landings).

Appendix 5: Timeline of Events

March 2017	
15 March	Mr Stewart remanded into custody at Maghaberry Prison Committal healthcare interview completed Mr Stewart requested a dental appointment and was accommodated in Bann House
16 March	Mr Stewart's Comprehensive Committal Assessment and Initial Mental Health Screen completed and a referral to the dentist was made Mr Stewart had a visit with his father and made a request to have his old telephone list from 2015 reactivated
20 March	Mr Stewart's Committal Induction and Medication Administration Record Card completed Mr Stewart had a dental appointment
21 March	Mr Stewart attended gym and manual handling inductions
23 March	Mr Stewart had an appointment with the Nurse. He placed an order with the Tuck Shop for a Gillette Mach 3 razor and blades
24 March	Mr Stewart had a video link court appearance and transferred from Bann House to Quoile House, Landing 2 A cell risk sharing assessment was completed and it appears Mr Stewart shared a cell for 1 day
30 March	Mr Stewart saw the Nurse who triaged him and made a referral to the GP
31 March	Mr Stewart had a video link court appearance
April 2017	
03 April	Mr Stewart had an appointment about housing arrangements for his release
07 April	Mr Stewart had a video link court appearance Mr Stewart moving to a different cell in Quoile House, Landing 2
11 April	Mr Stewart had a family visit

12 April	Mr Stewart had a dental appointment and was referred for a second opinion	
20 April	Mr Stewart had a family visit	
24 April	Mr Stewart requested a replacement pin card for the telephone	
25 April	Mr Stewart had a legal visit	
26 April	Mr Stewart had an appointment with the Doctor	
27 April	Mr Stewart's medication record card was updated and an in-possession medication risk assessment was completed	
May 2017		
05 May	Mr Stewart had a video link court appearance	
09 May	Mr Stewart had an appointment with the Nurse	
10 May	Mr Stewart attended a legal visit and a housing needs appointment	
11 May	Mr Stewart attended an urgent dental appointment, for a second opinion	
12 May	Mr Stewart moved from Quoile House to Lagan House, Landing 6 and his PREPS history was completed	
16 May	07:55	Permission to unlock
	08:45	Those attending workshops and education called to leave the House
	09:19-10:25	Mr Stewart had a visit with his girlfriend and her son
	12:20	Landings locked for lunch
	13:45	Landings unlocked
	17:10	Evening meal served at the servery
	19:25	Landing locked and numbers returned
	20:11	Cell alarm, Lagan House, Landing 5
	20:30	Cell alarm, Lagan House, Landing 3
	20:39	Medication issued to 1 individual in custody in Lagan House
	21:11	Patrol check completed

	22:11	Patrol check completed
	23:12	Patrol check completed
	23:43	Body check completed and note made that Mr Stewart was observed lying on his bed
17 May	00:05	Patrol check completed
	01:04	Patrol check completed
	02:07	Patrol check completed
	02:30	Cell checks begin
	02:33:02	Radio message raising alarm as Mr Stewart was lying on the floor of his cell
	02:33:31	Code Red alarm raised
	02:34:54	Radio request from the Prison Officer at the cell door to enter unaccompanied which was granted
	02:35:25	Ambulance requested
	02:51:10	First ambulance arrived at Maghaberry Prison
	02:58:00	Paramedics arrived in Lagan House, Landing 6
	03:02:13	Second ambulance crew attended
	03:19:00	Paramedics indicated output detected
	03:27:00	Paramedics Recognition of Life Extinct
	03:35:00	PSNI informed about Mr Stewart's death
	03:45:00	PSNI contacted Maghaberry Prison to request cell be secured
	04:15:00	Further telephone call to PSNI requesting update on time of arrival
	04:44:00	PSNI arrived at Lagan House
	06:31	Duty Governor contacted Mr Stewart's family and left a message. Mr Stewart Snr returned the call 6 minutes later at 06:37

	07:45	Hot Debrief took place (The Cold Debrief took place on 01 June 2017)