The Prisoner Ombudsman for Northern Ireland

INVESTIGATION REPORT
INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF

MR LAURYNAS STEPONAVICIUS
AGED 23

On 22nd February 2016

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Names have been removed from this report, and redactions applied. All facts and analysis remain the same.

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GLOSSARY

CJI	Criminal Justice Inspectorate
CPO	Custody Prison Officer
CPR	Cardio Pulmonary Resuscitation
CT Scan	Computerised Tomography Scan
ECG	Echocardiogram
EMIS	Egton Medical Information System
HMIP	Her Majesty's Inspectorate of Prisons
NICE	National Institute for Health and Care Excellence
NIPS	Northern Ireland Prison Service
PSST	Prisoner Safety and Support Team
SEHSCT	South Eastern Health and Social Care Trust

PREFACE

My office is responsible for investigating deaths in prison custody in Northern Ireland. We are completely independent of the Northern Ireland Prison Service (NIPS) and South Eastern Health & Social Care Trust (SEHSCT). Our Terms of Reference are available at www.niprisonerombudsman.com/index.php/publications.

We make recommendations for improvement where appropriate; and our investigation reports are published subject to consent of the next of kin, in order that investigation findings and recommendations are disseminated in the interest of transparency, and to promote best practice in the care of prisoners.

Objectives

The objectives for investigations of deaths in custody are to:

- establish the circumstances and events surrounding the death, including the care provided by the NIPS;
- examine any relevant healthcare issues and assess the clinical care provided by the SEHSCT;
- examine whether any changes in NIPS or SEHSCT 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.

Methodology

Our investigation methodology is designed to thoroughly explore and analyse all aspects of each case. It comprises interviews with staff, prisoners, family and friends; analysis of records in relation to the deceased's life while in custody; and examination of evidence such as CCTV footage and phone calls. Where necessary, independent clinical reviews of the medical care provided to the prisoner are

commissioned. In this case a review was undertaken by Dr Jane Rees, a GP with over 40 years' experience in primary care in England, including 11 years working in prisons and conducting reviews on behalf of NHS England.

This report is structured to detail the events leading up to, and the emergency response to Mr Steponavicius' death.

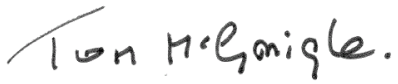
Family Liaison

Liaison with the deceased's family is a very important aspect of the Prisoner Ombudsman's role when investigating a death in custody.

I first met Mr Steponavicius' family on 18 February 2016 and contact has been maintained throughout the course of this investigation. I am grateful to the family for providing background information about Mr Steponavicius in the early stages of this investigation. The family were shocked that he ended up in prison in a foreign country and then apparently taken his own life. They found it difficult to understand the decision to accommodate him in the same cell as his co-accused, which they said is the opposite of what normally happens in Lithuania. At the conclusion of this investigation the family remained concerned about the decision to accommodate Laurynas with his co-accused and believe that if the NIPS had acted immediately on his request to be relocated to a different cell he would not have died.

I am grateful to Mr Steponavicius' family, the Northern Ireland Prison Service, the South Eastern Health and Social Care Trust and the clinical reviewer for their contributions to this investigation.

I express my sincere condolences to the family on their sad loss.



TOM McGONIGLE
Prisoner Ombudsman for Northern Ireland
18 July 2017

SUMMARY

Laurynas Steponavicius, a Lithuanian national, was remanded to Maghaberry Prison on 5th January 2016. He was found hanging on 11th February and died 11 days later at outside hospital, aged 23.

He had not previously been in prison in Northern Ireland, nor according to his family, in Lithuania. While there were procedural deficiencies in some assessments that were conducted upon his arrival, our clinical reviewer was satisfied that he was not exhibiting any evidence of mental illness or excessive distress during his first few days in Maghaberry.

Mr Steponavicius had asked to see PSNI officers while in prison and they visited him on the day before he died. He agreed to meet them again and told them that he felt safer in Maghaberry than in the community.

Despite this assertion to police, he requested transfer to another cell the next day: he had told his cellmate about his meeting with police and was anxious about possible consequences if this became more widely known. A Senior Officer (SO) promptly initiated the transfer request, but Mr Steponavicius took his life just two hours later.

There are discrepant accounts about whether Mr Steponavicius disclosed suicidal ideation to the SO prior to a nurse joining them in a meeting which took place two hours before he died. The SO was adamant that no suicidal ideation was expressed. Either of them could have commenced the Supporting Prisoner at Risk (SPAR) process if they were sufficiently concerned. The Nurse and SO both agreed that a cell transfer could have obviated the need for a SPAR. In the event this did not happen prior to his death.

Mr Steponavicius was not known to Maghaberry's Prisoner Safety & Support Team. As a young man in a foreign prison he was in a higher than average risk category; and the stress he experienced in his last few days, in relation to his fellow Lithuanian prisoners, could have generated a feeling of hopelessness that is commonly found in people who take their own lives. In addition to his meeting with the police he also appeared to be stressed by the relationship with his girlfriend, and also by his isolation as he did not have any visitors or contact with family during his time in Maghaberry. However he did not leave a note, so it is not possible to be sure about the weight he accorded to these matters.

After he died it transpired that Mr Steponavicius had previously suggested to fellow Lithuanian prisoners and to his girlfriend that he was contemplating suicide; and that he had made an unsuccessful attempt about a week before he completed suicide.

Unfortunately nobody passed this information on to NIPS officers or healthcare professionals because they did not believe he was serious.

Our clinical reviewer was satisfied that the resuscitation process was well-led and well-conducted by all the NIPS and SEHSCT staff who were involved when Mr Steponavicius was found.

This report makes four recommendations for improvement all of which have been accepted.

RECOMMENDATIONS

NIPS

1. Foreign national prisoners should be allowed to make a free international call upon committal if their designated next of kin does not live locally. (Page 17)

SEHSCT

2. The SEHSCT should ensure that smoking cessation support is developed in line with best practice, including a full range of medication and psychosocial treatments and regular monitoring of patients' progress. (Page 13)

3. The SEHSCT should ensure that staff have an awareness of factors which put prisoners at higher risk of self-harm or suicide, and ensure they look beyond prisoners' self-report. (Pages 13-15)

4. The SEHSCT should ensure that they are satisfied that Agency staff have the necessary level of SPAR training and that a record is made of such training (Page 15).

MAGHABERRY PRISON

Maghaberry is a high security prison which holds male adult sentenced and remand prisoners. It opened in 1987.

It has a Prisoner Safety and Support Team (PSST) whose responsibilities include supporting vulnerable prisoners. Mr Steponavicius was not known to the PSST.

Delivery of healthcare at Maghaberry transferred from the NIPS to the SEHSCT in 2008. Following a period of transition all Healthcare staff had become Trust employees by April 2012. The Trust subsequently increased the numbers of staff and the range of services provided. Healthcare is planned and delivered in line with primary care services in the community.

The Trust introduced a Primary Care Pathway with a dedicated committals team, providing comprehensive health screening within 72 hours of admission to the prison. It subsequently introduced a Mental Health Pathway and an Addictions Team was created in 2014.

An inspection report on the safety of prisoners in Northern Ireland was jointly published by the Criminal Justice Inspectorate and the Regulation & Quality Improvement Authority in October 2014. While inspectors saw evidence of good work in dealing with vulnerable prisoners, they also said joint NIPS/SEHSCT strategies were urgently needed to revise the Suicide & Self Harm policy and the Substance Misuse policy.

The subsequent report of an inspection of Maghaberry Prison, published in November 2015, found that aspects of healthcare provision had deteriorated, though a follow-up inspection report that was published in February 2016 found some aspects of primary health care had improved again.

Maghaberry has an Independent Monitoring Board (IMB) whose role is to satisfy themselves regarding the treatment of prisoners. Their 2015-16 annual report highlighted concerns about healthcare within Maghaberry.

FINDINGS

SECTION 1: INTRODUCTION & CONTEXT

Laurynas Steponavicius, a Lithuanian national, was remanded into the custody of Maghaberry Prison on 5th January 2016 after being charged with drug dealing offences.

He was found hanging on 11th February and died 11 days later on 22nd February at outside hospital. He was aged 23. The post mortem examination indicated a provisional finding of *"Death by hanging."*

Mr Steponavicius' solicitor said that he had a possibility of bail. A High Court application on 13th January 2016 had been adjourned generally for him to obtain a suitable address, but none became available before he died. A Home Office letter of removal had reportedly been troubling Mr Steponavicus, though his solicitor was unaware of it. A court appearance in early February 2016 was adjourned for two weeks until 16th February 2016 for the Public Prosecution Service to decide which charges to proceed with, and at what level of court they should be heard.

Maghaberry Duty Managers Report shows there were 837 prisoners and 29 staff on duty at handover on the night of 11th February 2016. 25 vulnerable prisoners were being managed on the Supporting Prisoner at Risk (SPAR) process. Nine of them were in Quoile House where Mr Steponavicius was accommodated, of whom two were in safer cells. There were three prisoners on dirty protest and 33 medical unlocks that night.

Mr Steponavicius was accommodated in four separate cells during his time in Maghaberry: during 5th - 8th January he was on the committal landings in Bann House. He spent 8th - 18th January on Quoile 3; and he moved to Quoile 2 on 18th January, where he remained until his death.

A cell-sharing risk assessment was conducted when Mr Steponavicius arrived in Maghaberry, and it was reviewed a fortnight later on 19th January. On both occasions he was deemed suitable to share a cell and, as is normal NIPS practice he was doubled with a fellow national in order to minimise their social isolation within the prison. Mr Steponavicius' cellmate was also his co-defendant. The NIPS does not place automatic restrictions on co-defendants sharing a cell unless the risk assessment indicates otherwise. No concerns were raised by anyone, including Mr Steponavicius or his cellmate, about this arrangement in their case.

Mr Steponavicius' cell on Quoile 2 contained written Information in Lithuanian about fire awareness, offences against prison discipline and a New Committal Information

Sheet. While services such as the Samaritans and Listeners are available, there was nothing to indicate how a distressed prisoner could access their services. Written information in the relevant language is issued to individual prisoners on committal and they can retain this information throughout their time in custody.

On 19th January Mr Steponavicius queried why he and his cellmate were moved from Quoile 3 - where they had Polish & Lithuanian friends - to Quoile 2, and he requested a return to Quoile 3. Prisoners are often moved to different cells for a variety of reasons including availability of space, progression, security and other logistics. The answer to his query was *"Due to operational reasons. Can be moved back if space becomes available."*

SECTION 2: COMMITTAL

Mr. Steponavicius was remanded to Maghaberry for drugs offences on 5th January 2016. When interviewed by a Nurse (Nurse A) in the prison Reception he said he did not have any physical or mental health problems or thoughts of self-harm. He did not report drug or alcohol addictions and was not taking any prescribed medication. Healthcare staff were unable to verify his medical history as Mr Steponavicius was not registered with a general practitioner in Northern Ireland.

Police records included a Forensic Medical Officer's assessment that was completed during Mr Steponavicius' time in their custody. These records did not identify any concerns other than a self-report of claustrophobia; and his solicitor indicated that Mr Steponavicius did not seem more vulnerable than any other detained person who is not familiar with the prison environment.

All the prison staff who contributed to this investigation said that at no point during their contact with Mr Steponavicius did he present as someone who was contemplating self-harm or suicide; and he denied it when asked. They reported that he was a quiet person who interacted well on the landing and caused no concern.

Records of various other prison committal screenings also confirmed Mr Steponavicius was not taking any medication, had no issues in relation to his mental health, no history of drug or alcohol abuse and no history or current thoughts of self-harm or suicidal ideation. He declined the offer of Language Line translation service during his Comprehensive Committal Assessment medical interview.

The Clinical Reviewer said that, although Laurynas Steponavicius' healthcare examination in the Prison Reception was brief, she was satisfied that at this stage he was not showing any signs of mental illness or undue distress. He denied suicidal intentions. His physical health was good and he did not have substance misuse problems. His command of English was reported to be good enough not to need translation services during his healthcare assessment. The Clinical Reviewer said his admission to prison could, therefore, be considered as fairly straightforward.

Healthcare

On 6th January 2016 Mr Steponavicius was seen by another Nurse (Nurse B) for a Comprehensive Committal Assessment. This assessment concentrated entirely on his physical health. On the same day, as part of the committal assessment process, a Nurse from the Mental Health team (Nurse C) conducted a mental health screen and

concluded there was no need to refer Mr Steponavicius for Mental Health support. The Mental Health Nurse made her assessment from the committal records. She was unable to corroborate Mr Steponavicius' medical history as he was not registered with a GP in NI and consequently there was no record on the Electronic Care Record (ECR).

Although a mental health screen was conducted as part of the committal assessment process the Clinical Reviewer stated that while Mr Steponavicius did not have a history of mental illness, he did have a number of factors that indicated a heightened risk of self-harm and suicide: young age, male gender, social isolation and foreign origin. None of these were recognised as heightening the risk of self-harm or suicide in this case.

On 22nd January 2016 following an alleged minor misdemeanour Mr Steponavicius was deemed medically fit for adjudication, though not for cellular confinement. In the event no disciplinary action was ultimately taken because his alleged misdemeanour was accepted as being due to his lack of understanding of the prison regime.

On 1st February 2016 Mr Steponavicius attended a nurse triage session and requested nicotine replacement patches as he had given up smoking the previous day. A Nurse (Nurse D) offered to get the GP to prescribe the patches for him and check their effectiveness. The nicotine patches were prescribed by a GP (Dr A) on 3rd February 2016 without seeing the patient. There is no record of any follow-up of Mr Steponavicius' response to the treatment or of a repeat prescription being generated for him.

Smoking cessation clinics are due to commence in Maghaberry from the end of April 2017.

On 6th February Mr Steponavicius was seen by a Nurse (Nurse E) at a triage clinic because he was complaining of anxiety and a fast heartbeat. The nurse recorded his blood pressure and a pulse rate of 114 beats per minute as within normal limits.

> The clinical reviewer said 114 beats per minute is not within normal limits. She said the average pulse rate in a healthy 23 year old male is 72 beats per minute within a range of 60 - 100. In Mr. Steponavicius' case the fast pulse was almost certainly a manifestation of a high level of anxiety and should have provoked further questions about his mood and mental state. This did not happen and he was given a GP appointment 11 days later.

Mr Steponavicius told the Nurse that he was anxious about being in prison and was having difficulty sleeping. The Nurse made a GP referral for 17th February but did not

explore why Mr Steponavicius was feeling anxious or record anything about his mood or state of mind.

Five days later, on 11th February, Mr Steponavicius again requested help for insomnia. Again he was offered a GP appointment, this time for 24th February, for poor mood and sedation. The Nurse (Nurse D) knew nothing of Mr Steponavicius' previous history as he had not examined his medical records on the EMIS computer system. The Nurse outlined a heavy workload as the reason for not doing so.

The Nurse told this investigation that he enquired about thoughts of self-harm and suicide, but Mr Steponavicius denied any such thoughts. As he had not accessed the medical records, the nurse was unaware that the insomnia was an ongoing problem or that Mr Steponavicius already had a GP appointment scheduled for 17th February.

This consultation was brief. It was conducted at the treatment room entrance because Mr Steponavicius seemed reluctant to enter the room. The Nurse explained that he attempted to explore possible reasons for his assessment of poor mood but Mr Steponavicius would not say what was troubling him.

The Trust acknowledge that a consultation made at the treatment room door is not best practice but this was an unscheduled consultation. The Nurse suggested prisoners sometimes worry that being behind closed doors could imply they are passing information.

Mr Steponavicius did not provide any reason for his insomnia on either occasion. Despite the nurse's observation of poor mood, the Clinical Reviewer commented the nurse did not refer Mr Steponavicius to the mental health team, inform prison staff, request an urgent GP appointment or initiate the Supporting Prisoners at Risk (SPAR) process. The Nurse did make a GP appointment following this unscheduled consultation.

Mr Steponavicius had other healthcare appointments which took place inside a room. If his demeanour on the 11th February was so anxious that he was unwilling to enter the treatment room, then the nurse should have been sufficiently concerned about his mental state to take further action such as informing Mr Steponavicius that he could access confidential support from the Samaritans or a Listener.

Quoile House has one GP clinic per week and when the clinic is full, patients have to wait until the following week for an appointment. In this case Mr Steponavicius was allocated appointments 11 days after his first request and 13 days after his second

request. Arrangements are in place for urgent GP appointments but the Nurse did not determine that this patient required an urgent appointment.

In Dr Rees' opinion, treatment for insomnia would not have cured Mr Steponavicius' anxieties, but an experienced GP would have been able to evaluate his needs and refer him for appropriate interventions which could have helped him cope with stress.

The Clinical Reviewer also explained that it is not uncommon for suicidal people to deny their intentions. She recommended that Healthcare staff who deal with vulnerable prisoners should look beyond prisoners' self-report when assessing suicide risk.

The Clinical Reviewer was also concerned that, although he claimed to have experience of opening and monitoring SPAR documents and some 'on the job' training, the Quoile House Nurse said he had not received formal training in the SPAR system.

SECTION 3: PSNI CONTACT

Mr Steponavicius had indicated during a phone call that he believed that talking to police would help his case. He made a written request to meet with PSNI officers on 29th January and on 10th February two officers visited him in Maghaberry.

The police followed proper procedure by booking a professional visit. They explained to Mr Steponavicius that he was free to leave at any time and offered a translator, which he initially declined.

Mr Steponavicius discussed his charges and told the police his passport was lost. When police queried if it was lost or had been taken from him, he became unable to understand what they were asking. He said a translator could assist and the police offered to meet again with a translator. Mr Steponavicius said he would be happy to do so.

At the conclusion of the meeting Mr Steponavicius told police that he had fears for his safety when he would get out of prison, but was not concerned within the prison. He said he got on with the people in Quoile House and had no issues about remaining there. That would appear to certainly have been the case on 19th January, when he had requested a return from Quoile 2 to to Quoile 3 on behalf of himself and his cellmate/co-accused in order to be nearer their Polish & Lithuanian friends.

Prisoners who provided evidence to this investigation said they were unaware of this meeting with police. They also said there were no threats against Mr Steponavicius within the prison. However after he died, his cellmate indicated in phone calls that he was aware Mr Steponavicius had spoken to the police. He said Mr Steponavicius had told him he expected to be *"taken to the forest"* after being released.

SECTION 4: SOCIAL INTERACTION

Other prisoners said Mr Steponavicius initially thought he was coming to Ireland to do an "honest" job, but had no resources to return home when he realised that was not the case. His family were all in Lithuania. He had no contact with them during his time in Maghaberry and they were unaware that he was in prison. He did not receive any visits, did not have additional money placed in his account and, therefore only had a weekly wage of £4 to buy tuck shop items and phone credit. He never had more than £10.30 in his account which meant there was little opportunity to make phone calls or buy cigarettes.

Nine days after committal, Mr Steponavicius requested a free international call. This request was refused and he was informed instead about the facility to reverse call charges. It is not known who he intended to call.

His only external contact was phone calls with a girlfriend, whom he had identified as his next of kin when he arrived in Maghaberry. It transpired after his death that she was a 15 year old Lithuanian schoolgirl who was living in Northern Ireland with her mother. She did not visit during his time in prison.

In one phone call with this girl he asked her to get his mother's telephone number for him, but that never transpired. In another call he described having no clothes and *"looking like a tramp."* He also told her his passport had been taken from him.

It was clear from the phone calls that his girlfriend's failure to visit after numerous requests, and her delays in responding to his requests added to Mr Steponavicius' frustration. During their last call on 10th February he was disappointed that she did not visit or get clothes to him via another Lithuanian who was visiting the prison. He also questioned her over rumours that she was seeing someone else.

Prisoners with whom Mr Steponavicius associated said he was concerned about serving a lengthy sentence if convicted. They also said he was consumed with thoughts that his girlfriend was cheating on him. They knew he suffered from low mood and suicidal ideation, but they did not report it to staff because nobody believed he was serious when he talked about ending his life. They attempted to encourage him, told him that he was young and had his whole life ahead of him. However his behaviour appeared to change during the two weeks before his death, when he became less communicative and more stressed.

The day after Mr Steponavicius died, his cellmate disclosed to a Senior Officer (Senior Officer A) that he had told him a couple of weeks earlier that he was contemplating suicide. The cellmate now felt guilty about not sharing this

information with staff. A SPAR was promptly opened on the cellmate, which was proper procedure.

Another Lithuanian prisoner said Mr Steponavicius had actually tried to hang himself about a week before his successful attempt.

Before Laurynas died, his girlfriend told the prison officers who were guarding him in hospital that he had disclosed suicidal intent to her during a phone call on the day before he died. However neither the unsuccessful attempt nor conversation with his girlfriend, were reported to prison staff.

Other Lithuanian prisoners said they did not realise the situation was so serious and they tried to support him after the failed suicide attempt. They were unaware of tensions between him and his cellmate, other than the fact that his cellmate could become stressed by Mr Steponavicius' low mood.

Throughout his time in Maghaberry Mr Steponavicius shared a cell with his co-accused who was also Lithuanian. His cellmate's phone calls (pre- and post- Mr Steponavicius' death) and the accounts of some other prisoners suggest the cellmate was unsympathetic towards Mr Steponavicius, and possibly at times unsettled him in relation to matters outside prison and his girlfriend.

CCTV footage from unlock on 10th February until the evening of 11th February shows that Mr Steponavicius was interacting well with other Lithuanian prisoners: he played cards and collected meals which he took back to his cell. Occasionally on 11th February he could be seen walking around the landing alone, apparently deep in thought.

SECTION 5: 11TH FEBRUARY

Tripartite meeting

On 11th February Mr Steponavicius approached a Custody Prison Officer (Officer A) for a private conversation. He had consulted with a nurse earlier in the day, and as he appeared nervous the prison officer brought him into the Education Room. He told her he had been talking to police the previous day and was worried about it. The Officer told him she would inform the Quoile House Senior Officer (Senior Officer A), which she promptly did.

The SO brought Mr Steponavicius into his office for a meeting around 1510 hours. Because Mr Steponavicius was nervous and agitated, the SO also invited the house nurse (Nurse D) - with whom Mr Steponavicius had consulted earlier that day - to participate.

Mr Steponavicius said his cellmate/co-accused knew that he had spoken to the PSNI and had warned him about what may happen to him and his family. He therefore wanted to leave his current cell and go into a single cell on same landing, or move landings or house to avoid any potential trouble.

Mr Steponavicius felt compromised by a Polish prisoner seeing him in the SO's office during the meeting as he did not want to be regarded as an informer. However the SO reassured him that the matter was being treated confidentially and a note was given to Mr Steponavicius with details of a GP appointment, which provided a legitimate explanation for his presence in the SO's office.

The meeting lasted 20 minutes. The SO concluded by telling Mr Steponavicius he would speak to the Security Department to establish whether there were any available cells on another landing or in a different house. He felt Mr Steponavicius was content with that reply. There was no concern about him returning to his cell or landing and he went directly back there after the meeting.

The SO explained that he could have immediately moved Mr Steponavicius to another cell in Quoile House. However as there was a risk that he might move him to a location where he had enemies, the SO conformed to normal procedure by requesting a move via the Security Department, since they would have the most complete and up to date information to help ensure his safety.

There is a discrepancy between the Nurse and the SO as to whether Mr Steponavicius disclosed suicidal thoughts to the SO prior to the Nurse joining the tripartite meeting. In the Nurse's EMIS record and at interview (July 2016), the Nurse said that the SO told him that Mr Steponavicius had expressed suicidal

thoughts prior to the Nurse joining the meeting. However, the Nurse did not record this detail in a statement made shortly after Mr Steponavicius' death (February 2016).

The SO (Senior Officer A) indicated at interview (in July 2016) that he had not made any notes in relation to the tripartite meeting. However in September 2016 he submitted a statement which he said was made on the night of Mr Steponavicius' death.

At interview and in his statement the SO was adamant that Mr Steponavicius did not express suicidal thoughts prior to the Nurse joining the meeting nor during the meeting; and that if he had done so, then the Supporting Prisoners at Risk (SPAR) process would have been initiated immediately. The SO said that at no time did the Nurse suggest that a SPAR needed to be opened, and this concurred with the SO's own opinion. The differing accounts which the SO and Nurse provided of this meeting are confusing and this investigation has been unable to determine which is correct.

Both the SO and the Nurse said Mr Steponavicius was unclear and non-specific during their conversation. His nervousness was apparent to both and they concurred that he was more settled at the end of the meeting. The SO and Nurse both stated that Mr Steponavicius had been asked several times during the conversation if he felt suicidal and he had denied this on all occasions. However the Nurse also described Mr Steponavicius as *"distraught,"* said his anxiety was escalating and he was *"pleading to be moved."*

The Clinical Reviewer said that given this level of anxiety, coupled with his earlier presentation in the treatment room, it is concerning that the Nurse did not see fit to commence the SPAR process.

Both the nurse and SO appear to have agreed that this was not a healthcare matter and that a cell move could have obviated the need for a SPAR.

The SO's record shows that he contacted the Security Department immediately after the meeting was advised to complete a Security Information Report (SIR). He did so, and forwarded it to the Security Department within ½ hour of the tripartite meeting. The SIR indicated that Mr Steponavicius felt under pressure from outside and inside the prison following his meeting with the police, that he was extremely nervous and wanted to move out of Quoile House for his own safety. It also indicated that PSNI had verbally reported that they were not in possession of any information to suggest a threat from his cellmate; and that the situation would be further assessed the next day. Consequently the SIR was being considered "*pending confirmation of Mr Steponavicius' meeting with the PSNI."*

Prisoners frequently request cell transfers, for a variety of reasons; and the speed of the assessment depends on several factors, including corroborating evidence. In Mr Steponavicius' case there was no suggestion of imminent risk from his cellmate, so this approach appears to have been appropriate.

The Quoile SO subsequently phoned the Security Department to confirm they had received the SIR, which they had. He called the Security Department twice more, around 1645 and 1715 hrs, to ask if any decision had been made based on his SIR. He spoke with two officers, both of whom indicated there was no update.

11th February evening

With only six officers available, Quoile House was on a restricted regime. At 1730 the Quoile 1&2 prisoners were unlocked to be fed and for association.

The pod officer said he was very busy, working alone for 90% of time. His role was to observe and control movement in the house with the assistance of CCTV monitors and grilles, and to observe SPARs.

His focus was on several vulnerable prisoners who were on SPARs and he was also watching for aggressive behaviour among other prisoners. He was not watching Mr Steponavicius as he was not known to be vulnerable or aggressive and was not on a SPAR. Nor would he have regarded a single prisoner accessing the yard as a reason for specific monitoring. In order to access the yard, a prisoner would have to draw attention to himself by waving at the POD officer. The pod officer said it would not have been difficult for Mr Steponavicius to conceal a ligature when he exited to the yard alone.

The pod officer did not notice Mr Steponavicius accessing the yard toilet or note if the light was activated. Subsequent review of CCTV footage of Mr Steponavicius in the yard shows that he reconnoitred the area before entering the toilet at 17:53. However there was nothing in his demeanour that would have aroused suspicion at the time. The toilet had a half-door for privacy and a sensor-controlled light. The interior was not covered by CCTV camera.

Had a SPAR been opened, it is possible that Mr Steponavicius would not have been allowed to access the exercise yard alone, and therefore the opportunity to take his own life at that stage could have been averted. However it is also possible that he would have been allowed out alone in order to have some peace and quiet.

At 1815 Quoile 1&2 (where Mr Steponavicius lived) began to lock so that staff could supervise association on Quoile 3&4.

At 1823 a Custody Prison Officer (Officer B) advised that a prisoner was missing. He checked with the pod but was unable to locate him. As no-one had left the house, the only other place he could have been was in the yard. The CPO checked the yard and at 1828 he found Mr Steponavicius in the yard toilet. He had tied a ligature around the toilet area and was found hanging from it. The CPO immediately cut him down using a Hoffman knife and tried to administer cardiopulmonary resuscitation (CPR).

This was just over two hours after Mr Steponavicius had raised his concerns with the SO and nurse. No other prisoners were in the yard at the time.

An emergency ambulance was summoned and the other Quoile House prisoners were ordered to lock up.

Resuscitation attempt

The SO and an officer responded immediately. The SO said there was blood on the face and shirt of the officer who found Mr Steponavicius, and he was noticeably shaken. The officer had cut his finger while using the Hoffman knife. Two CPOs (Officers B and C) maintained CPR and compressions until Healthcare staff arrived.

Four nurses (Nurse F, Nurse G, Nurse H and Nurse I) went to the yard immediately and took over the CPR. They noted that Mr Steponavicius' pupils were fixed and dilated and he was unresponsive to stimuli. An Automated External Defibrillator (AED) was available, however, as it did not record any shockable rhythm there was no clinical indication for its use. Mr Steponavicius' family expressed concern that the defibrillator was not working correctly, but I have not been able to substantiate this.

The Ambulance Service first responder arrived on the wing at 18.55, followed shortly afterwards by a full ambulance crew. Paramedics took over CPR but were unable to establish a pulse.

Mr Steponavicius was brought to the Intensive Care Unit of Craigavon Area Hospital by emergency ambulance where he was placed on life support. Subsequent investigations showed that he had a suffered a catastrophic brain injury due to hypoxia (lack of oxygen) and that it was not possible for him to recover from the brain damage he had suffered. He died on 22nd February.

Our clinical reviewer was satisfied that the resuscitation process was well-led and well-conducted. All the NIPS officers involved were trained in basic life support. The nurses in attendance managed the CPR well and were successful in keeping Mr Steponavicius alive until the ambulance crew took over. There was no delay in summoning the ambulance or in transferring him to hospital; and the nurses kept in regular contact with the hospital while Mr Steponavicius was there.

SECTION 6: POST INCIDENT

Hospital

A Governor from Maghaberry phoned the person whom Mr Steponavicius had nominated as his next of kin when he came into prison - his "partner" - to inform her of the situation. When she explained she had no other way of visiting him at Craigavon Hospital, a Governor (Governor A) drove to Portstewart to bring her to the hospital. Only then did it become apparent that the partner was only 15 years of age, too young to give consent for medical interventions and ineligible to act as his next of kin. NIPS officials subsequently managed to contact Mr Steponavicius' immediate family in Lithuania.

A prison chaplain attended the hospital when Mr Steponavicius arrived there.

On 14th February a Governor (Governor B) visited the hospital. Prison officers on bedwatch duty were relieved by a managers' presence as they felt ill-prepared to respond to queries about what to do in the event of cardiac arrest when medical intervention could not be authorised in the absence of next of kin. There was also a query about possible organ donation; and a phone call from a person claiming to be the family solicitor, to whom an officer felt unable to give out information over the phone.

Mr Steponavicius' family arrived in Northern Ireland on 16th February. His mother and an uncle had the first visit with him at hospital, and other relatives were also able to visit. A cousin and a family friend were refused a visit as they were not on the visitation order.

Hot Debrief

A hot debrief was conducted on 12th February. It was chaired by a Governor (Governor C), and 17 others participated including IMB and SEHSCT staff. The officer who had found Mr Steponavicius was absent as he had been sent to hospital to be treated for the cut inflicted by the Hoffman knife.

The record shows that a pro-forma approach was applied. This was comprehensive and addressed quality of actions, access to the scene, including by emergency services, aftercare for prisoners and staff. The debrief specifically dealt with

- *"What went well?"* (Privacy screening at the scene and joint NIPS/SET work, including ECR); and

- *"What needs remedial attention?"* (Nothing was identified at that stage but participants were encouraged to raise any issues that subsequently occurred at the cold debrief).

An Independent Monitoring Board representative noted the hot debrief *"was well-conducted."* They said the incident was very efficiently and quickly managed with everyone doing all they possibly could to help Mr Steponavicius, his cellmate and each other.

Cold Debrief

A cold debrief was conducted on 26th February 2016. It was chaired by a Governor (Governor A) and had 14 others in attendance plus one e-mail contribution. The pro-forma record addressed the fact that Mr Steponavicius had never hinted to anyone in authority that anything was wrong; and concern about him being able to nominate a 15 year old girl as his next of kin.

Several issues were addressed:

- Problems with Blick alarms not always sounding. The outcome was that Blick alarms were to be tested daily and faults reported to the Trades Department;
- Defibrillator management post-incident was a concern. As it was unclear who should check used defibrillators, a process was to be initiated for their management and for replacement pads to be made readily available. The cold debrief also generated a recommendation for all NIPS staff to have AED training;
- Next of kin must be aged over 18;
- The CPO whose finger was cut had attended hospital alone, on medical advice, though NIPS management was unaware of this until the hot debrief;
- Two Custody Prison Officers (Officers B and C) were referred for commendations for their response when it was noticed that Mr Steponavicius was missing.

A CPO also raised concern about staffing levels in Quoile House on the night that Mr Steponavicius died: there were six officers to manage a population that included several prisoners who were on open SPARs. However the Quoile SO countered that Mr Steponavicius' death could have taken place earlier if a full complement of staff had been on duty as this would have provided prisoners with earlier access to the yards. He also identified as positive the fact that staff carrying Blick alarms meant the alarm was raised promptly; and availability of Hoffman knives meant Mr Steponavicius was cut down quickly.

A Nurse (Nurse J) advised no issues had arisen for Healthcare staff and nurses had access to all equipment they needed, with extra oxygen tanks brought to the area as

a precaution. There had not been any difficulty in accessing Quoile House or the yard, and the incident ran smoothly.

Mr Steponavicius' cell and landing were sealed as soon as he left Maghaberry, and they remained sealed until PSNI and Prisoner Ombudsman examinations were completed.