The Prisoner Ombudsman for Northern Ireland

INVESTIGATION REPORT
INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF

MR GAVIN MAWHINNEY
AGED 27
MAGILLIGAN PRISON
ON 04 FEBRUARY 2019

Date finalised: **25 January 2023**

Date published: **22 February 2023**

The role of the Prisoner Ombudsman

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

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 Coroner. Reports are also disseminated to those who provide services in prisons.

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Glossary

A&E	Accident and Emergency Department
AD:EPT	Alcohol and Drugs**:** Empowering People Through Therapy
CCTV	Closed-Circuit Television
CPR	Cardiopulmonary Resuscitation
CRUSE	Cruse Bereavement Support
CSU	Care and Supervision Unit
CT	Computerised Tomography
CTR	Compassionate Temporary Release
DVD	Digital Versatile Disc
ECR	Emergency Control Room
ENCOMPASS	New Regional Electronic Health Records System
GP	General Practitioner
ICU	Intensive Care Unit
IMB	Independent Monitoring Board
IPC	Inmate Personal Cash Account
IT	Information Technology

NIAS	Northern Ireland Ambulance Service
NIPS	Northern Ireland Prison Service
PD	Dissociative Personality Disorder
PDU	Prisoner Development Unit
PIPE	Psychologically Informed Planned Environments
PREPS	Progressive Regimes and Earned Privileges Scheme
PRISM	Prisoner Record and Inmate System Management
PSNI	Police Service of Northern Ireland
PSST	Prisoner Safety and Support Team
RQIA	Regulation and Quality Improvement Authority
RVH	Royal Victoria Hospital, Belfast
SPAR	Supporting Prisoners At Risk (procedure)
SPAR Evo	Supporting Prisoners At Risk Evolution (procedure)
SEHSCT	South Eastern Health and Social Care Trust
The Prison Service	The Northern Ireland Prison Service
The Trust	The South Eastern Health and Social Care Trust
TV	Television

Foreword from the Ombudsman

Introduction

The death of a loved one is always difficult. The fact that a death occurs in prison is particularly challenging given the loss families experience when a loved one is taken into custody and the trust they must place in the Prison Service, the Trust, and others, to ensure the safety and wellbeing of their loved one.

All those in custody should expect to be treated decently and with respect, receiving the best care possible for their wellbeing and rehabilitation. Above all, families need to have confidence that their loved one is safe while in custody.

Findings made in this report, together with learning identified, will address and inform those who provide care for people in custody. Where appropriate, I will make recommendations directly to the Prison Service and the Trust. Both organisations provide my office with a response indicating if they accept my recommendations and what steps they are going to take, or have taken, to address them.

While improvements in the provision of care for people in custody is important to ensure confidence, this report is written with Mr Mawhinney's family primarily in mind. It is critical that, as far as we can, we provide explanations and insight to bereaved relatives. I am conscious of the length of time families wait for investigative processes to complete. Mr Mawhinney's family have been keen to hear the results of my investigation and I acknowledge the delays that have arisen, not least due to the impact of Covid-19. I appreciate their patience and continued engagement and am grateful to them for their contribution to this investigation.

My investigation

It is important that I establish, as far as possible, the circumstances surrounding Mr Mawhinney's death. I hope that this information will be helpful to the family as they piece together the last events in Mr Mawhinney's life. I commissioned a clinical review to consider the healthcare Mr Mawhinney received and the outcome of that review is contained within my report. 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 Mawhinney.

Overview of events leading up to Mr Mawhinney's death

Mr Mawhinney was admitted into custody on 11 November 2017 following a period of mental ill health. He had spent time in mental healthcare immediately preceding his committal and had a history of contact with services such as addiction and self-harm.

In May 2017 Mr Mawhinney had been detained in Downshire Hospital and while no ongoing mental health input was referred at that stage it was noted that he had a diagnosis of Dissocial Personality Disorder. He had been admitted to hospital earlier in the week when he came into custody and had refused to be assessed by the psychiatrist. Mr Mawhinney continued to have healthcare support, including mental healthcare, while in custody.

Most of Mr Mawhinney's time in custody was spent at Maghaberry Prison but in preparation for his release he was moved to Magilligan Prison on 01 November 2018.

Mr Mawhinney was the father of 4 children. Throughout his time in custody he was driven by a desire to be a good father and his goal was to get out of prison and see

his children. While there were difficulties in this respect the commitment Mr Mawhinney felt to his children is not in question. He completed courses that would inform and support him in his commitment and regularly spoke of his desire to provide a stable family life and be a good father.

While in custody Mr Mawhinney was diagnosed with epilepsy. How his epilepsy would impact his daily life was still to be fully understood at the time of his death. He did face mental health challenges while in custody and some of these led to behavioural issues.

Mr Mawhinney experienced considerable loss in his life, including the deaths of family members and friends. He was not happy with his move to Magilligan Prison as he felt he would be less likely to receive visits from the family and friends on whom he relied. Whether this would have been the case and whether he would have come to appreciate the different regime and opportunities offered at Magilligan Prison is unknown given the short period of time he spent there.

On 26 November 2018 Mr Mawhinney moved to Cell 45 H2 D-Wing at Magilligan Prison. The following day he was interviewed about his release which he anticipated would be to his mother's home. He had a bail hearing date of 11 February 2019.

On 28 December 2018 Mr Mawhinney received an upsetting letter which has been a focus within my investigation. On 29 December 2018, during the evening headcount, Mr Mawhinney was found unresponsive in his cell and taken to Causeway Hospital. Sadly Mr Mawhinney did not recover but died at the Royal Victoria Hospital, Belfast, on 04 February 2019. The loss suffered by Mr Mawhinney's family is intensified by the fact that they had anticipated home leave eligibility from 11 February 2019 with a release date in June of that year.

I offer my sincere condolences to Mr Mawhinney's family on their sad and painful loss. I hope this report provides information to address some of the questions they raised and explains events leading up to his death. The learning, expressed in recommendations, will, I hope, bring some comfort and confidence to those who have family members in custody.

DR LESLEY CARROLL
Prisoner Ombudsman for Northern Ireland
25 January 2023

Section 1: Recommendations

1.1 Recommendations List and Factual Accuracy Responses

Recommendation 1: Sharing information with individuals in custody transferring to another prison The Prison Service should review, and where possible update, information provided in the transfer van to ensure it assists those on transfer to orientate themselves to their new surroundings and regime.
The Prison Service accepted this recommendation
Recommendation 2: Sharing information with Prison Service Staff The Trust and Prison Service should review how information is provided to staff on the landings to ensure they are fully aware of what is required to provide effective support to each individual in custody. This should include how to clearly record information about triggers and stressors.
The Prison Service accepted this recommendation. The Trust did not accept this recommendation.
Recommendation 3: Family contact The Prison Service should consider appointing a named contact (or contacts) for families where there is protracted illness or when death has occurred and that guidance for Prison Officers on bedwatch duties be reviewed, updated and reissued.
The Prison Service accepted this recommendation
Recommendation 4: Sharing Risk Information The Prison Service and Trust should review how information related to the risk of suicide or self-harm is shared to ensure Prison Officers have the information they need to respond appropriately to individuals in custody and their behaviours.
The Prison Service and Trust accepted this recommendation

1.2 Areas raised in previous reports: kept under review

I do not repeat the recommendations made in previous reports but note the progress made and plan to keep these matters under review.

Debrief meetings: Standard 25 of the Prison Service '*Suicide and Self Harm Prevention Policy 2011 (updated 2013)'* states 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 involve all the staff, where possible, who were closely involved with the incident. The purpose is to provide staff with an opportunity to express their views in relation to how the situation was discovered and managed, and any additional support or learning that could have assisted.

The cold debrief is expected to 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. This also provides a further opportunity to check in with staff involved in an incident.

In an investigation published in June 2021 I noted that some staff had not attended the debrief meetings although follow ups were put in place to support them. In an investigation published in March 2020 I noted that no cold debrief had taken place and that the Trust had advised they were continuing to expand their staff care programme to include a trauma informed approach. I have kept this development under review and am aware of the following significant activity to support staff:

From March 2020 the Trust have introduced a range of activities that support a trauma informed approach. These activities include the following:

- Trauma Awareness training;
- Reflexive Practice sessions – led by Clinical Psychology/Mental Health practitioners;
- Attending and presenting at Action Trauma Network conferences;
- Lunch and engage sessions;
- Appraisal conversations that include discussion about personal wellbeing;
- Facilitated away time and team relationship building; and
- The Trust Live Well website and free access to yoga/mindfulness/walking groups/art groups among others

Following an independent review of support services for prison staff and the introduction of the Crisis Incident Management Procedures a significant number of Prison Service staff are now trained and in place to offer support.

In the case of this investigation issues were raised at debrief meetings, an individual member of Trust staff was noted to follow up, the individual was not present at the meeting and no one passed the request on. This has since been resolved but I remind the Prison Service of recommendations made in previous reports about clearly assigning named individuals or departments to implement learning[1], about staff attendance at hot and cold debriefs[2] and about Governors assuring themselves that hot and cold debrief meetings are conducted.[3] As all these recommendations relate to support procedures at Magilligan Prison the Governor may wish to review the good functioning and effectiveness of hot and cold debriefs overall and ensure improvement.

Section 2: Background information

2.1 Magilligan Prison

Magilligan Prison is a medium security prison which holds male adults sentenced to custody mainly transferred from Maghaberry Prison. The population of Magilligan Prison on the day of this incident was 433 (464 on the day of Mr Mawhinney's death). The focus of care and support at Magilligan Prison is on providing people in custody the opportunity to reduce their risk of reoffending and prepare them for release.

Since 2008, the Trust has provided prison healthcare services. There is a 24 hour primary healthcare service and the Mental Health Team is on site Monday to Friday between 08:00 and 17:00. There are no in-patient beds.

2.2 Criminal Justice Inspection NI (CJINI)

The most recent inspection report of Magilligan Prison was published in February 2022. A number of notable areas of positive practice were recorded by Inspectors including a culture of care driven by PSST and the application of the SPAR Evo approach, which enabled effective care to be delivered to the most vulnerable, Family Support Officers working in partnership with others to sustain and promote family contact and the use of video technology to allow those in custody to support their children virtually. Of the 4 healthy prison tests which CJINI measure against when conducting their inspections, 1 had stayed the same while 3 had declined:

[1] Report of investigation into the death of Mr L published August 2018: 'The NIPS should ensure that learning points identified at debrief meetings are clearly assigned to a named individual or department to implement and include clear timescales for completion.'
[2] Report of investigation into the death of Mr L published August 2018: 'The NIPS and SEHSCT should ensure those staff involved in a death in custody attend the initial hot and cold debrief meetings.'
[3] Report of investigation into the death of Mr Bernard Law, September 2019: 'The Governor should ensure that effective hot and cold debrief meetings are conducted following a death in custody.'

safety remained in the same band while decline was noted in terms of respect, purposeful activity and rehabilitation and release planning. In her Foreword the Chief Inspector commented:

> *With the concerning exception of access to illicit substances and high rates of positive drug tests, all the other evidence pointed to an establishment that continued to offer a stable and safe environment, with very little violence and an approach to safeguarding the vulnerable that enabled good oversight and co-ordination of personalised care.*

2.3 Independent Monitoring Board (IMB)

Magilligan 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 2018/19 Annual Report, the IMB reported a reduction in complaints relating to Healthcare which had been maintained. However, they also noted an increase in the incidence of individuals in custody with mental health issues and difficulties addressing them in the prison environment. They welcomed the provision of a Mental Health Wellbeing Hub to provide the mental health team with a base for their work and clients a place for therapeutic interventions, an important development given the noted increased numbers presenting with mental health issues.

With regard to the H2 block in which Mr Mawhinney was living, the IMB note refurbishment and improvements completed in that year and ongoing.

2.4 Regulation and Quality Improvement Authority (RQIA)

The RQIA is the independent body responsible for regulating, inspecting and reviewing the quality and availability of health and social care services. In the course of their reviews RQIA identify best practice and highlight gaps or shortfalls in services requiring improvement. All their reviews aim at protecting the public interest.

Following a report of an incident of serious self-harm in 2016[4] from my office and the number of suicides among those in custody a review was commissioned jointly by the Departments of Health and Justice. In August 2020, following a meeting with the Director, Reducing Offending and representatives of the Trust, I had made a further request for work such as this to be completed . In that request I raised concerns about adequate information being shared between community and prison healthcare and between services working within prisons, including the Prison Service itself, to ensure that individuals in custody received the best possible healthcare. My request was specifically that alternative models of care arising from concerns

[4] Report of Investigation into an incident of Serious Self-Harm, Sean Lynch, 06 September 2016

identified in current death in custody investigations be examined. RQIA published their report in October 2021.[5] It goes some way to addressing my request.

2.5 Previous incidents at Magilligan Prison

The incident that led to Mr Mawhinney's death took place at Magilligan Prison in December 2018. There had been 2 deaths at Magilligan Prison during 2018 both of which appear to have been from natural causes. There are no significant similarities with these deaths.

[5] RQIA, *Review of Services for Vulnerable Persons Detained in Northern Ireland Prisons, October 2021*

PART A: INVESTIGATION AND FINDINGS

Section 3: Framework and scope for investigation

Mr Mawhinney died at the Royal Victoria Hospital (RVH), Belfast, on 04 February 2019. He had been admitted to hospital on 29 December 2018 following an incident in his cell when he was found unresponsive. He was released, under Rule 27.2[6], on 31 December 2018 in order that his family could be with him without restriction and allowing privacy. As the incident causing Mr Mawhinney's death took place 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 set out on page 2, which include providing explanations, where possible, to Mr Mawhinney's family.

3.1 Questions raised by Mr Mawhinney's family

I met with Mr Mawhinney's family in March 2019 to hear directly from them. Issues raised and agreed for consideration in this investigation were:

- The precise circumstances/timeline leading up to Mr Mawhinney being transferred to hospital (there were discrepancies in accounts given to the family about the time of lock up), the timing of a concert relative to a telephone call with his Mum that afternoon, how he was transferred to hospital, how long the resuscitation had taken and how long he had been without oxygen, what the Governor meant when saying that 3 of them had been involved, what Mr Mawhinney had used to harm himself and what a Prison Officer meant when he said it had taken Mr Mawhinney some time to do what he did, a Prison Officer had also said that Mr Mawhinney must have had it in his head because he had asked to be single celled;
- Why Mr Mawhinney had no trousers or underwear on when Mrs Mawhinney arrived at the hospital and she also commented that he was wearing a navy t-shirt which she had not left in for him;
- The absence of any marks on Mr Mawhinney's neck and if there was any other explanation resulting in him being treated in hospital (Mrs Mawhinney's suspicion was that he had been attacked);

[6] Rule 27.2 allows for the compassionate release of individuals in custody who are seriously ill without requiring bedwatch staff

- The background to an incident when he had been charged for verbally abusing a Prison Officer and any potential impact of this on his death;
- The background to him being in the Care and Supervision Unit (CSU) and if he was under threat from another inmate; and
- The content of the 'Dear John' letter and any potential impact this had on Mr Mawhinney.

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 the death of Mr Mawhinney were issued to relevant parties on 06 February 2018, including those in custody, the Prison Service and IMB. The following information was gathered and analysed by my Investigating Officer:

- Prison Service records including Closed-Circuit Television (CCTV) footage, radio transmissions and telephone calls made by Mr Mawhinney prior to his death;
- Interviews with Prison Service and Healthcare staff;
- Interviews with individuals in custody; and
- Medical records.

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

3.3 Independent advice

When appropriate, I commission an independent clinical review of specific aspects of healthcare. A clinical reviewer is commissioned from an agreed list, usually to deliver a peer review of healthcare provision, and they supply a report with recommendations. My office provides the clinical reviewer with relevant documentation and a Terms of Reference specific to each case to enable them to provide an independent, expert opinion about an individual in custody's care. A clinical reviewer may, for example, assess delivery of care in relation to current clinically approved guidelines, local and national and/or consider policy and practice within the relevant prison. They will keep in mind whether or not care has equivalency with that provided in the community, note any good practice 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.

I commissioned Professor Jenny Shaw, a Consultant Forensic Psychiatrist at Greater Manchester Mental Health Foundation Trust and Professor of Forensic Psychiatry at the University of Manchester, to provide an independent clinical review of the healthcare provided to Mr Mawhinney. As a forensic psychiatrist she has particular experience of assessing and treating patients involved in the judicial process and in the preparation of psychiatric reports.

In Mr Mawhinney's case, Terms of Reference for the clinical review were agreed, see Appendix 1, and Professor Shaw considered the following specific areas:

- The adequacy and effectiveness of the assessment and care planning provided to Mr Mawhinney on the 5 occasions he underwent the application of the Suicide and Self-Harm Prevention Policy when in prison
- The post incident debrief process and support services to staff and individuals in custody
- Examples of good practice

Professor Shaw was also invited to highlight any other issues she thought could be important. She provided me with a report setting out her opinion on the matters she was asked to consider. I have included her opinion on relevant matters in this report.

3.4 Scope and remit of this investigation

The scope and remit of my investigation must meet the standards set out in Terms of Reference for Prisoner Ombudsman NI investigations of deaths in custody. These apply to every investigation and are found on Page 2 of this report and more fully at Appendix 2. These overarching Terms of Reference, together with questions from the family and Terms of Reference for the clinical review, inform the scope and objectives of this investigation which are:

1.	To establish a chronology of events, specifically leading up to the time when Mr Mawhinney was found in his cell and taken to hospital, including a timeline of responses until his death.
2.	To establish the existence and significance of stressors present for Mr Mawhinney leading up to the time of events on 29 December 2018, how they were identified and how they were responded to, particularly as he had a history of self-harm.
3.	To examine the effectiveness of clinical care provided to Mr Mawhinney.
4.	To identify any learning for the future.

Section 4: Chronology of events and timeline of responses

4.1 Section introduction

To underpin my investigation a chronology of events leading up to Mr Mawhinney's death is critical and informs my assessment of how Mr Mawhinney was cared for while in custody. The chronology also informs answers provided to questions raised by Mr Mawhinney's family. This will include:

- Information about when Mr Mawhinney was committed into custody and his time at Maghaberry Prison
- Mr Mawhinney's transfer to Magilligan Prison
- How he settled into Magilligan Prison
- Questions raised by Mr Mawhinney's family

4.2 11 November 2017 – 01 November 2018: Committed into custody, Maghaberry Prison and move to Magilligan Prison

Mr Mawhinney was committed into custody at Maghaberry Prison on 11 November 2017 on charges of arson being reckless as to whether life would be endangered, attempted criminal damage and common assault. At the time of his death Mr Mawhinney was serving a determinate custodial sentence. His earliest date for release would have been 11 February 2019 when he would have been released on licence. Mr Mawhinney died on 04 February 2019. Most of his time in custody was served at Maghaberry Prison and he transferred to Magilligan Prison on 01 November 2018 to complete his sentence. I will discuss his move to Magilligan Prison in Section 5.4.

4.3 01–26 November 2018: Meetings, house moves and hospital

On 08 November 2018, at Magilligan Prison, Mr Mawhinney had a wellbeing interview with the Prisoner Development Unit (PDU). Notes of the interview indicate that he was feeling stressed about the move and frustrated about his clothing which he had not received since his arrival.

On 11 November 2018 Mr Mawhinney had a seizure in his cell and prison records show he was taken out to hospital at 19:30 and returned to Magilligan Prison at 23:59. Mr Mawhinney had begun to experience seizures while in custody and on a previous occasion, while in Maghaberry Prison, he had been taken to hospital. On 13 November 2018 Mr Mawhinney put in a request to locate his missing clothing, claim for any clothing that was lost and amend his clothing card accordingly.

On 14 November 2018 a representative of CRUSE Bereavement Support spoke with Mr Mawhinney who reported he had concerns about family members and their ability to visit. He also said he had no money for the phone and he wanted to call his mother. Records show that the previous day, 13 November 2018, Mr Mawhinney had been granted a phone call to his mother and he spoke with her for about 10 minutes. The Governor also placed £3 credit on his phone on 14 November 2018. This information was appropriately shared between the PDU, CRUSE and the Senior Officer in Halward House where Mr Mawhinney was housed at the time.

Mr Mawhinney had a second interview with the PDU on 15 November 2018 and over the next 10 days he saw Nurses A and B regularly to receive his medication. On 17 November 2018 Mr Mawhinney was moved to the CSU where he remained until he moved to H2 D-Wing. His move to the CSU was on Rule 32(1), applied for his own safety. Officers explained to him that he was not in the CSU as punishment but so that he would be safe and Mr Mawhinney is recorded as having understood this. I will discuss this in more detail in Section 5.6.

On the afternoon of 26 November 2018 Mr Mawhinney moved to Cell 45 H2 D-Wing. The following day, 27 November 2018, he was interviewed about housing and a release address. He informed staff that he had been living with his mother before he came into custody and he hoped to be released to the same address.

4.4 December 2018: Settling into H2 D-Wing

During December 2018 Mr Mawhinney saw healthcare on a number of occasions, including in relation to another seizure on 06 December 2018. He engaged in education, met with his solicitor and expressed an interest in becoming an orderly. This was a challenging time for Mr Mawhinney as he attempted to settle into his new environment and on occasion he found himself in dispute with staff. For example, on 10 December 2018 inmate notes record that Mr Mawhinney had approached Prison Officer B for hot water about 18:30 even though a call had been made for everyone needing hot water at 18:00. His request was denied but Mr Mawhinney refused to lock and asked Prison Officer B to get the Senior Officer. He accused Prison Officer B of denying him what he was entitled to. Another individual in custody gave him some hot water but Mr Mawhinney threatened that he would not lock up. He ultimately complied and notes record that his behaviour should be monitored as he was keen to have an orderly position. The following day, 11 December 2018, Prison Officer C noted in inmate notes that Mr Mawhinney had come to the class office, on C-Wing landing, to ask about an orderly position. Prison Officer C recorded that he had challenged Mr Mawhinney about his behaviour the previous evening. Mr Mawhinney was annoyed and walked away, according to the notes, saying that staff had it in for him.

4.5 28 December 2018: Mr Mawhinney received an upsetting letter

On the morning of 28 December 2018 post was brought to the wing and distributed by one of the Prison Officers on duty. Mr Mawhinney received a letter, which he found upsetting; he was distressed about what it would mean for him. Others in custody and Prison Officers described the letter to my investigator in a number of ways. Some described it as very personal, others as a very difficult letter. One individual on the landing described it as more of a wake-up call than him being 'dumped.' Mr Mawhinney himself found the letter distressing and reportedly described it as 'being kicked to the kerb.' A number of others in custody on the landing and at least two Prison Officers saw the so-called 'Dear John' letter. One individual in custody, Individual A accompanied by another, Individual B, showed the letter to Prison Officers D and E about 11:00 on the morning of the 28 December 2018 as they were concerned that Mr Mawhinney was upset.

At 11:06, Mr Mawhinney telephoned the author of the letter to say its content had upset him. The author of the letter explained that they needed to focus on their child and that they should not see each other. They reiterated that they were not seeing anyone else and they wanted to see change in Mr Mawhinney so that he would again be the person they had met. As things stood, they thought they were not good for each other. Mr Mawhinney said he had been working hard, keeping his head down and had passed drugs tests. Mr Mawhinney asked if he could speak to his child and did so for over a minute. He was pleased to tell his friends later.

Some on the landing told my investigator that they saw Mr Mawhinney walking around the landing that morning and that he looked distressed and upset. Prison Officer F recalled speaking to Mr Mawhinney about football bets around 11:00. He reported that Mr Mawhinney had good eye contact and there was nothing in the conversation that raised any concerns. My investigator carefully observed CCTV and saw no evidence of Mr Mawhinney being visibly upset as he walked around the landing that morning.

Between approximately 11:10 and 11:40, Prison Officers D and E made their way to Mr Mawhinney's cell to speak with him. Prison Officer D said they had been concerned as Mr Mawhinney's letter, which they had seen, was 'not a nice letter' and they wanted to check on him. Both Prison Officers said that Mr Mawhinney appeared to be coping and he had the company of a number of others in his cell with him. Prison Officer D spoke directly with him about the letter, said to him that at least he would see his children and assured him that he could come and speak to them at any time if he needed to. Prison Officer D reported that Mr Mawhinney showed no signs of distress nor signs he had been crying. As there were no particular concerns and as Mr Mawhinney seemed to understand that he could speak with them should he have concerns, no journal record was made either about the letter being received

or any potential concerns arising from it and a SPAR Evo was not considered. I will revisit this matter in Section 5.7.

Mr Mawhinney made a number of calls throughout that day, 28 December 2018. He contacted friends and family several times. In all the calls, he spoke about his upset by the letter and in one of those calls; he said he was 'thinking about saying goodnight.' He ended the call by arranging to phone the person again. He told one of those whom he called that, he had wrecked his cell because he was so upset and that he was upset because he had not been able to speak with his mother. I could find no evidence that Mr Mawhinney had wrecked his cell. One other person on the landing did say that Mr Mawhinney had punched the wall, but my investigator was unable to corroborate this.

Later that day Mr Mawhinney spoke with his mother twice, for over 8 minutes, and he discussed his feelings with her. They particularly spoke about how difficult it can be as a release date approaches and his mother encouraged him to focus on his bail hearing date, 11 February 2019. He complained about his clothing and how he could not get the clothes she had sent him as they were on his clothing rack[7] and he also complained that he had no money.

Mr Mawhinney's final phone call was on 28 December 2018 to a friend whom he had spoken to earlier in the day. They had previously discussed future plans together and on this call they discussed a possible visit. Mr Mawhinney spoke positively about visiting arrangements at Magilligan Prison and was very keen for them to visit. He said he would get them the details and ring them back the next day.

4.6 29 December 2018: Mr Mawhinney discovered hanging

The next morning, 29 December 2018, immediately after unlock, another individual in custody, Individual A went to see Mr Mawhinney in his cell and found him still upset. Individual A reported that Mr Mawhinney said he wanted to share a cell with him and that he, Individual A, went to ask but the request was refused. It is unclear if or when this request was made or responded to. Prison Officer F reported no memory of being asked and explained that if he had been asked and refused he would not necessarily have logged this in the landing journal or on inmate notes. Some others on the landing spoke about the request to share a cell but still others had no such knowledge. It is, therefore, impossible to establish with certainty that this occurred but it will be important for the family to note that if Mr Mawhinney made any request with regard to his accommodation it would more likely have been a request to share rather than to remain in a single cell.

[7] The clothing rack is what people in custody call the area where their out of cell clothing is stored

Afternoon unlock began at approximately 14:10 but the house was locked again at approximately 14:20 when another individual in custody needed medical attention. An ambulance had to be requested and the person was taken to hospital resulting in those in custody on H2 remaining restricted to their cells.

Despite this locked period, Mr Mawhinney went out to a church service at 14:50 with three others and returned at 15:17. Mr Mawhinney's landing, D-Wing, was unlocked at 15:29 to allow those in custody to pick up their evening meal. Other landings were not unlocked and staff delivered meals to cells. The landing was locked again at 15:43. Another individual in custody activated the cell alarm at 16:25 and asked Prison Officer G to take tobacco to Mr Mawhinney, which he did. By 16:40 the wing was locked for the evening, headcounts had been completed and two Prison Officers were on duty, one in the control room and one on the landing.

The next headcount took place at around 19:30 when Prison Officer H came on duty. Shortly before headcount, between approximately 5 and 10 minutes, Mr Mawhinney was talking through the window to another individual in custody, Individual C, who said Mr Mawhinney was not talkative but he did respond.

At 19:33 a Code Blue[8] was raised by Prison Officer H who had opened the flap of Cell 45 and observed Mr Mawhinney hanging from a ligature, formed from a co-axial cable and a belt, attached to his window. What followed is logged in statements, a number of written Prison Service and Trust records, the ambulance service log and the prisons emergency call record.

19:33	• Code Blue alarm raised. • Prison Officers H, I and J ran to the cell. • Prison Officers H and I cut the ligature and lowered Mr Mawhinney. • Prison Officer J commenced Cardiopulmonary Resuscitation (CPR).
19:35/36	• Nurse C arrived at H2 Cell 45 and found a male lying on the floor not breathing and CPR was in progress. • Nurse C recorded that ligature marks were clear and there was a report of medication possibly having been taken.

[8] A Code Blue is an emergency call code used to summon healthcare staff when there is a life-threatening medical situation. A Code Blue is used when someone is not breathing, cannot speak in sentences or is unresponsive.

	• Defibrillator pads were placed on Mr Mawhinney's chest but did not indicate for a shock and Mr Mawhinney showed no pain response. • A number of empty tablet strips were identified. • Two further Prison Officers arrived on the landing to assist. • Ambulance requested.
19:50	• Nurse C administered naloxone[9] with no effect.
19:55	• Further dose of naloxone administered by Nurse C.
19:58	• First responder in relation to the ambulance request (a paramedic) arrived and entered the cell.
20:09	• Second paramedic arrived and 3 further doses of naloxone administered resulting in sinus rhythm. • By 20:15 Mr Mawhinney's blood pressure, pulse and oxygen levels were increasing but there was still no pain response.
20:25	• Ambulance arrived at H2. • Mr Mawhinney had begun to deteriorate again. • It was agreed to transport Mr Mawhinney to Causeway Hospital.
20:34	• Mr Mawhinney left the prison by ambulance, accompanied by Prison Officers F, K and L. • On arrival at Causeway Hospital Mr Mawhinney was taken to the resuscitation area of the A&E Department.
21:00	• The Prison Service was informed that Mr Mawhinney had arrived at Causeway Hospital. • Prison Officer K telephoned the Police Service of Northern Ireland (PSNI) to inform them about the incident.
21:54	• Mr Mawhinney's cell was locked and sealed by Prison Officer H, witnessed by Prison Officer M.

At Causeway Hospital, while in the A&E Department, Mr Mawhinney was ventilated with a breathing tube and transferred for a scan to establish more information about his injuries. He returned to the A&E Department after his scan and was kept sedated to be assessed the next morning. At 22:35 the next of kin was informed about what

[9] Naloxone is a medicine that is administered to rapidly reverse opioid overdoes

had happened and they immediately contacted medical staff at Causeway Hospital A&E Department. By the time the family arrived at the hospital, shortly after midnight, Mr Mawhinney had been moved to the Intensive Care Unit (ICU).

Mr Mawhinney's family kept vigil by his bedside over the next days and at 18:00 on 31 December 2018, the Prison Service placed Mr Mawhinney on a Rule 27.2 meaning Prison Officers withdrew from bedwatch to give the family more privacy. Governor A tried to telephone Mrs Mawhinney to explain the meaning of Rule 27.2 however when she was unable to make contact she asked Prison Officer N, on duty at the hospital, to inform the family and explain what this meant.

Mr Mawhinney remained sedated and at Causeway Hospital until 04 January 2019 when he was moved to Antrim Area Hospital to wait for a neurology bed at the RVH, Belfast. A bed became available on 05 January, the following day, so Mr Mawhinney was moved immediately to the RVH where he remained until his death on 04 February 2019. During this time Mr Mawhinney's friends and acquaintances at the prison asked about him daily. Prison Officers have spoken of the significant impact events had on them, not least because some of them had attended other deaths in custody.

4.7 Materials found in Mr Mawhinney's cell

When evidence was gathered from Mr Mawhinney's cell a number of loose documents were recovered:

- A note instructing where any money in his Inmate Personal Cash (IPC) account should go
- A note to his solicitor instructing where any outstanding claims should go
- A note to a friend expressing how hard he had found things over the last few days
- A note to his mother expressing his love for her
- A note to his former partner
- A complaint regarding missing clothing, dated 15 December 2018, that had not been submitted

4.8 Questions raised by Mr Mawhinney's family

1.	**Time of lock-up on 29 December 2018** It is recorded that the whole house was in 'night mode,' that is those in custody were locked in their cells with supplies for the night such as hot water, by 16.40.
2.	**The timing of a concert and phone calls on 29 December 2018**

	A concert is noted in Mr Mawhinney's diary on 28 December 2018 for 12:30-13:30 and the landing journal records the movement of people to and from a concert at those times. Mr Mawhinney did not attend but no reason is recorded. There are no phone calls listed for Mr Mawhinney on 29 December 2018. He had made a number of calls on the previous day, including several calls to his mother.
3.	**What Mr Mawhinney used to hang himself and what a Prison Officer meant when he said it would have taken Mr Mawhinney some time to do this** Mr Mawhinney made a ligature from a belt and co-axial cable which he attached to his cell window. During the course of my investigation it has not been possible to establish which Prison Officer made the alleged statement that it would have taken Mr Mawhinney some time to do this. It is, therefore, impossible to say what he may have meant.
4.	**Whether or not Mr Mawhinney had specifically asked to be in a cell on his own given a Prison Officer is reported to have said that he must have had this in his mind** There is no evidence to suggest that Mr Mawhinney had specifically asked to be in a cell on his own. During his time in Maghaberry Prison Mr Mawhinney had shared a cell on a number of occasions and on arrival at Magilligan Prison he was assessed as being an appropriate person to share a cell with someone else (Section 5.4). Some individuals in custody reported that Mr Mawhinney had asked to share a cell but these reports could not be confirmed with any certainty.
5.	**Who was involved in the immediate response and what their roles were** Prison Officer H who was carrying out the first evening headcount discovered Mr Mawhinney. Prison Officer H immediately raised a Code Blue and entered the cell with two colleagues, Prison Officers I and J. Prison Officer I cut the ligature using a Hoffman knife, Prison Officer H took Mr Mawhinney's weight and with Prison Officer J lowered him to the ground. Nurse C arrived at Mr Mawhinney's cell 3 minutes after having been called and immediately began to assist with CPR. Nurse C took the decision to administer naloxone given the empty packets of medication in the cell.
6.	**Mr Mawhinney's transport to hospital, including how he was dressed** Mr Mawhinney was transported to hospital by ambulance at the paramedic's decision. There is no record of how Mr Mawhinney was dressed when he left the Prison. The post-mortem report notes that when he was found Mr Mawhinney was fully clothed. Hospital records show that Mr Mawhinney was catheterised in the A&E Department. No other information was discovered about how Mr Mawhinney was dressed.

Section 5. Identifying and responding to Mr Mawhinney's stressors

5.1 Section introduction

The purpose of this Section is to provide an overview of stressors for Mr Mawhinney, paying particular attention to his mental health history using information drawn from reports of his appointments with healthcare, Trust records generally, Prison Service records and the information and view provided by the clinical reviewer. By stressors I mean events or experiences which could cause Mr Mawhinney some distress or anxiety or which could result in low mood, acts of self-harm or other mental and emotional wellbeing impacts or exceptional behavioural responses.

I will consider his history of self-harm and how that was responded to using the Supporting Prisoners at Risk (SPAR) procedures. I will assess if there were any known stressors that could have given insight into how Mr Mawhinney might have been feeling and experiencing life at the time when he self-harmed on 29 December 2018. Stressors for an individual can arise from life history and experience, experience in prison, mental health diagnoses, learning difficulty or other significant events. This Section will therefore include:

- A mental health survey and history
- Information about Mr Mawhinney's SPAR history including what could be drawn from that record with regard to stressors for him and whether this information was appropriately shared
- Mr Mawhinney's transfer to Magilligan Prison and the impact this transfer may have had on him, including how information about Mr Mawhinney was shared between prisons
- Mr Mawhinney's relationships with Prison Officers and others in custody
- The time Mr Mawhinney spent in the CSU at Magilligan Prison and whether this was appropriate
- Questions raised by Mr Mawhinney's family

5.2 Mental health survey and history

Mr Mawhinney first came into custody when he was 25 years old and he was 27 when he died. This experience in itself can be a stressor in the life of an individual. In terms of Mr Mawhinney's mental health, records note that he had a history of depression & anxiety and attempted suicide & self-harm.

In 2017, Mr Mawhinney spent some time in hospital to receive mental healthcare. He described the arson incident, for which he was remanded into custody and then sentenced, as an incident with 'suicidal intent.'

While in mental healthcare, Mr Mawhinney was diagnosed with dissociative personality disorder (PD). His mental state assessment at that time noted poor sleep and appetite, particularly when anxious, and that while he denied being a violent person he could be aggressive and non-compliant. At that time, he identified a number of psychosocial stressors including paramilitary threat, having been in care as a child, breakdown in relationships and children whom he had no access to. Other traumatic events in his life are noted throughout Mr Mawhinney's records: the death of two friends in accidents, the death of his grandfather and uncle and a serious health diagnosis for a family member in 2019.

Mr Mawhinney's challenges included addictions and during his time in custody he was referred for and requested support from Alcohol and Drugs: Empowering People Through Therapy (AD: EPT), a support programme for people with addictions. When Mr Mawhinney was admitted into custody in 2017, he was placed on a SPAR which is the procedure the prison service applies for Supporting Prisoners At Risk (SPAR) of self-harm and suicide.

Mr Mawhinney was aware of and could articulate stressors in his life and he had some awareness that the experiences of his life had an impact on his wellbeing and behaviour. It is important to note that such insight can be built on in response to challenging situations. For example, at an appointment with a psychiatrist, Dr F in January 2018, while he was in custody, he was able to inform Dr F that he had a personality disorder and a history of self-harm, including arson due to stress. The psychiatrist noted that Mr Mawhinney described anxiety, panic attacks, low mood, feelings of guilt and recurrent intrusive and disturbing thoughts and images. Dr F noted a:

> '… persistently negative appraisal of his situation, intolerance of environmental noise and the intrusion of other prisoners into his personal space, a preference for solitary based activities and on-going security fears.'

Over the months following this appointment, Mr Mawhinney saw the Mental Health team for support and medication review on a number of occasions. Records of these appointments together with other records from his time in custody, for example records of incidents that resulted in SPARs being opened further describe his emotional world: his history of impulsivity, anger and intolerance of stress, difficulty regulating his emotions, irritability and restlessness. A psychology report of 16 April 2018 noted cognitive distortions, lack of consequential thinking, alcohol misuse and an unstructured lifestyle. Mr Mawhinney reported that his mood had improved due to the structure prison life provided for him.

His impulsivity and difficulty in regulating his emotions inevitably led to some clashes with Prison Service staff, which I will reference in Sections 5.5 & 5.7. There is a high likelihood that some of these are recorded as non-compliance or bad behaviour. I will discuss this further in Section 6.3.

Mr Mawhinney engaged in education at both Magilligan and Maghaberry Prisons. Of particular note was his engagement with the *Family Matters*, '*Being a Dad*' programme at Maghaberry Prison. This was especially important to Mr Mawhinney, as it was a step on the way to his being able to see his children. This hope was a significant motivator for him and he often referenced his children.

Health records note that Mr Mawhinney's behaviour and difficulty coping with emotional stressors were in keeping with PD. He had ongoing mental healthcare support through appointments and medication and via the Prison Service SPAR procedures. How the significant stressors in his life were identified and responded to through SPARs will be examined in the next Section and I will address mental health appointments in the learning section of this report.

5.3 SPAR (Supporting Prisoners At Risk) history

It is critical that those in custody who may be at risk because of mental ill health or their emotional state are properly assessed and supported. At the time when Mr Mawhinney was in custody this support was delivered through SPAR procedures as set out in the 2011 Suicide and Self Harm Prevention Policy, updated 2013. This policy aims to identify vulnerable persons at risk, provide support to them and the care they need to minimise harm. A multi-disciplinary approach is taken to enable effective response.

Following mental health and risk factor assessments a range of responses can be provided including regular observation, appointments with the Prisoner Safety & Support Team (PSST) and in cases of significant risk this can mean placing an individual in an observation cell where they can be regularly checked. A safer cell and safer clothing are applied when the risk merits. When a SPAR is closed a multi-disciplinary case conference is held. Mr Mawhinney was placed on a SPAR a number of times during his time in custody and was provided with a variety of these supports.

30 June 2018: placed on SPAR and taken to observation cell

In light of his mental health history, Mr Mawhinney was referred for psychotherapeutic interventions in June 2018. While this support was important Mr Mawhinney continued to struggle and on 30 June 2018 he took an overdose. He had received a letter which caused him distress and he identified other stressors arising from what was happening to a family member. He identified the overdose as a

reaction to these stressors. He was taken to an observation cell where he was observed every 15 minutes. On 01 July 2018, observations were reduced to 30 minutes when he reported he had no current thoughts of self-harm. The SPAR was closed on 06 July 2018 followed by a post-closure SPAR review on 13 July 2018. While the letter was identified as activating increased stress, it is clear that Mr Mawhinney acknowledged ongoing stress, consistent during his time in custody.

This account of response to a stressor in Mr Mawhinney's life is significant given that on 28 December 2018, the day before Mr Mawhinney was found unresponsive and taken to hospital, he had received a letter, which he found upsetting. It is important to ask whether such information would have been valuable for the staff on H2 at Magilligan Prison and if it would have been, to consider how the information could be effectively communicated to them. I will address this in Section 5.8.

27 July 2018: placed on SPAR and 15 minute observations

On 27 July 2018, Mr Mawhinney self-harmed and as a result, 15-minute observations were put in place. Records note he had thoughts of self-harm and low-mood. On that day, Mr Mawhinney had received news of the death of a family member and that a court hearing was on hold. Referrals to CRUSE and mental healthcare were arranged for Mr Mawhinney who had requested but was denied, compassionate temporary release (CTR) for the funeral. By 29 July 2018 Mr Mawhinney reported he could keep himself safe and would make use of the Samaritans phone should he need to. The SPAR was closed on 01 August 2018 and a post-closure interview and case conference took place on 08 August 2018.

04 September 2018: placed on SPAR and 30 minute observations

Mr Mawhinney was again placed on a SPAR on 04 September 2018 when he reported that his 'head is going' because of the impact of another individual in custody's death and upcoming funeral. At his SPAR interview, he reported other stressors, including no phone credit, other bereavements and a concern to see his children. He was placed on 30-minute observations and reminded that he could use the Samaritans phone. Prison Service records show this SPAR was closed on 11 September 2018 and he was referred for stress pack, mindfulness, depression management, relaxation therapy, cook it, learning skills and sleep hygiene.

On 17 September 2018, Mr Mawhinney saw a prison doctor and spoke about the stressors noted over the previous months and the anxiety he was feeling.

01 November 2018: SPAR Evo Concern Form completed

On 01 November 2018, a SPAR Evo Concern Form was completed when Mr Mawhinney arrived at Magilligan Prison. This was an appropriate completion of the risk assessment required when an individual in custody transfers from one prison to

another. At that time, Magilligan Prison was applying the new SPAR Evo procedures which I will discuss in Section 6.4.

5.4 Transfer to Magilligan Prison

Mr Mawhinney transferred to Magilligan Prison on 01 November 2018 having been aware since September 2018 that his transfer was to take place. A cell sharing risk assessment carried out at the time of transfer noted no issues regarding sharing. Mr Mawhinney was unhappy with the decision to transfer him. As records are scant, it is unclear to me on what grounds the transfer to Magilligan Prison took place. It would have been helpful for some information about Mr Mawhinney's transfer to have been noted. This matter has been addressed in Prison Service guidance of January 2019 *Criteria for Transfer of adult male prisoners to HMP Magilligan* which sets out how records need to be kept and who can access them. This will include discussions about transfer and reflect the decision making process.

One of the reasons Mr Mawhinney was unhappy with his transfer was that he felt he would not have as many visits, particularly from a family member. It is impossible to make a direct comparison between the number of visits he received at Maghaberry Prison and those he received at Magilligan Prison given he had only been at Magilligan Prison for 2 months. It is possible to say, from visits records, that visits had been less frequent at Maghaberry Prison for a number of months before his transfer due to family illness. When visits are not possible telephone contact with family and friends is critical to an individual in custody's wellbeing. The January 2019 *Criteria for Transfer of adult male prisoners to HMP Magilligan* also set that matters such as this should be taken into consideration when a decision to transfer is being made.

When family and friends visits those in custody, it is an opportunity for them to place money into an Inmate Personal Cash Account (IPC account). On a number of occasions, Mr Mawhinney reported that he did not have money in his IPC account to make the phone calls that were important to him. Magilligan Prison staff arranged for him to have money transferred into his IPC account by postal order and this arrangement was to continue for as long as he had no visits. Regular deposits into his IPC account are visible from records, including by postal order, and at the time of his death, he had £65.22 in his IPC account. When requested, the Governor also granted Emergency credit to Mr Mawhinney's account for example on 19 November 2018.

On 06 November 2018, Mr Mawhinney submitted a request to the Governor to be moved back to Maghaberry Prison citing distance from his family as the main reason for his request. On 17 November 2018, he received a response from Prison Officer O saying that there was an outbreak of norovirus at Maghaberry Prison and as a result, all transfers were suspended. The Trust have confirmed the outbreak of norovirus in November 2018.

In preparation for moving to a different prison, a comprehensive information booklet is given to those on transfer to assist them with orientation to a new place. I am aware that further work has been completed to make use of the IT facilities in the transfer van to support orientation. I welcome this approach as the sense of safety provided by a known environment can be significant given the possibility of increased anxiety in new surroundings. This is particularly true for those who already have anxiety challenges. I am recommending that a review of information provided at transfer is carried out to ensure it provides useful support.

Recommendation 1: Sharing information with individuals in custody transferring to another prison

The Prison Service should review, and where possible update, information provided in the transfer van to ensure it assists those on transfer to orientate themselves to their new surroundings and regime.

Mr Mawhinney's property transferred with him to Magilligan Prison but he was annoyed that some of his clothing and personal items were held in reception for some time. On 13 November 2018 he put in a request to claim for missing clothing. A response to his request confirmed that his personal items were present in reception but not his clothing. Clothing was also an issue for Mr Mawhinney as some of his laundry appeared to have gone missing. On 25 November 2018 he raised a complaint about his missing property and on 13 December 2018 this matter was resolved.

5.5 Relationships on the wings

Mr Mawhinney was described by others who knew him on the landings as being 'a good laugh' and 'outgoing' while some staff described him as 'jokey' and 'full of fun.' It appears that at times he liked to keep himself to himself but he also shared cells a number of times. Mr Mawhinney had known some others in custody over years and had been upset at the death of one of those friends. Given that Mr Mawhinney was approved for cell-sharing on transfer to Magilligan Prison, as he had been when he was admitted into custody at Maghaberry Prison, it would appear that relationships with others in custody were not of concern.

Records from his time in Maghaberry Prison reveal that Mr Mawhinney had mixed relationships with staff, which is not unusual. He is noted as being argumentative at times and as keeping staff at arms-length but at the same time not presenting any

major issues. This was recorded in his Progressive Regimes and Earned Privileges Scheme (PREPS) report, 09 August 2018 and 11 October 2018. His time on the H2 landing at Magilligan Prison was short so records are limited. In that short time there were some issues regarding his attitude. These were recorded by Prison Officer P in his PREPS report 28 December 2018 where Mr Mawhinney's tendency to be argumentative and challenge rules was noted. Again this would not be unusual during a period of resettlement.

Mr Mawhinney made a complaint about Prison Officer Q on 08 September 2018 while in Maghaberry Prison. He complained that while he was leaving visits Prison Officer Q had spoken to him, expressed a concern that he was on a SPAR and as Mr Mawhinney reported it Prison Officer Q had said, "I hope you don't hang yourself.' The Prison Service carried out an investigation and confirmed that the Prison Officer had been on duty. The complaint was escalated to the Duty Governor, Governor C, who viewed CCTV but no evidence could be found to corroborate the allegation. I am content from records available that the complaint was properly handled.

At my first meeting with Mr Mawhinney's family they had referenced a complaint about a Prison Officer which they were concerned had impacted his behaviour. At a further family meeting in August 2021 I was able to establish more information.

The family were interested in one particular situation when they understood Mr Mawhinney was alleged to have spoken about a Prison Officer in a threatening way. Situations such as these are treated as offences, adjudicated according to Prison processes and awards are given should the individual be found guilty. For example, losses can be incurred such as loss of gym, tuckshop or earning and regime demotion can also result from adjudications. The last adjudication recorded for Mr Mawhinney took place on 04 September 2018 while he was still at Maghaberry Prison. He was charged with using foul and abusive language to a Prison Officer regarding a complaint form. There was no award in this instance. Mr Mawhinney's adjudication record at that time displays some deterioration in behaviour between July and September of 2018. He was charged with using foul and abusive language 4 times and received a variety of awards including loss of gym and sports privileges, loss of earnings, loss of tuckshop, loss of evening association and loss of Television (TV)/Digital Versatile Disc (DVD)/video. Given these adjudications happened when Mr Mawhinney was at Maghaberry Prison they are highly unlikely to have impacted events on 29 December 2018 at Magilligan Prison.

While relationships with staff were sometimes volatile for Mr Mawhinney I have found no evidence requiring further investigation of this matter.

5.6 The Care and Supervision Unit

Mr Mawhinney spent one period in the CSU during his time in Magilligan Prison. He was moved to the CSU for reasons of his safety on 17 November 2018, under Prison Rule 32 (1)[10]. Prison Officer R explained the situation requiring the move to him and he appears to have understood and raised no objection. Prison Officer R recorded that Mr Mawhinney was content with the explanations provided and made no further comment about threats alleged against him.

Records show that a threat against Mr Mawhinney had been alleged, requiring his safety to be prioritised. Mr Mawhinney had experienced threats previously, while in the community, and there is always the possibility that an experience such as this will have a negative effect. However, there is no evidence that this was the case for Mr Mawhinney.

While in the CSU Mr Mawhinney requested emergency phone credit so he could speak to a family member. This was granted. He was also seen regularly by a nurse to receive his medication. In my view the move to the CSU was sensible and appropriate. Mr Mawhinney appears to have understood the situation and his care was satisfactory.

5.7 Stressors: were they identified and satisfactorily responded to?

Mr Mawhinney had a diagnosis of dissociative personality disorder. He expressed suicidal ideation, had identified triggers and a history of self-harm. He had support from the mental health team and regular appointments with a General Practitioner (GP) to review how he was feeling and his medication.

Mr Mawhinney had a significant number of behavioural triggers and these, including his lack of awareness of the consequences of some of his actions, related to his personality disorder and resulted in him facing discipline or being placed on a SPAR. I have found no evidence to suggest that any of these processes were applied improperly.

As already mentioned, Mr Mawhinney's relationships with others in custody were generally good but those with staff were sometimes volatile. His family relationships could also be somewhat volatile. Mr Mawhinney lived with a constant desire to be a good Dad, see his children regularly and live in a family setting. As the possibilities for this happening were limited Mr Mawhinney applied himself to change but the

[10] 32. –(1) Where it is necessary for the maintenance of good order or discipline, or to ensure the safety of Officers, prisoners or any other person or in his own interests that the association permitted to a prisoner should be restricted, either generally or for particular purposes, the governor may arrange for the restriction of his association.

intrusion of his disposition for self-harm often derailed him. Nevertheless, he maintained his hope of being a father who was good for his children.

Given the importance of family, Mr Mawhinney found his transfer to Magilligan Prison difficult. He interpreted the move as meaning he would not see his family, one implication being that he would not be able to receive monies into his prison account to pay for phone calls to keep in touch with them. The prison helpfully made arrangements to mitigate his concerns by agreeing to money being deposited into his account by postal order for as long as he had no visits.

Sadly, Mr Mawhinney did not have sufficient time at Magilligan Prison to see the benefit of the different environment and opportunities. There were a number of reasons for this alongside the short time he had been there, including:

- Ten days spent in the CSU shortly after his arrival
- Health care challenges including one that resulted in him having to be taken out to hospital following a seizure
- It was almost a month before he began to settle into his own cell
- The beginning of December brought a focus on Christmas that can impact regular timetabling as well as an individual's emotions

I have found nothing recorded over the 2-month period in which Mr Mawhinney was at Magilligan Prison to raise concerns that would indicate how he was cared for could have had an impact on his actions on 29 December 2018.

It is important to note that one of Mr Mawhinney's SPARs, while he was in Maghaberry Prison, was due to him receiving a letter that caused him stress. On 01 July 2018 Mr Mawhinney presented in Braid House, Maghaberry Prison, with 'his head all over the place.' He had received an upsetting letter and was feeling anxious and depressed. He informed staff he had taken an overdose and as a result he was placed on 30 minute observations. The SPAR was closed on 06 July 2018. This was a proper SPAR response, as set out in the older SPAR process applicable at that time, due to his self-harm resulting from the stressor.

It is important to ask: If Prison Officers had known such information on the wing at H2 in Magilligan Prison when a letter that was causing Mr Mawhinney stress was shown to them; would their response have been any different?

While this is a question with hindsight it can be an important illuminator of why sharing information can make a difference. One Prison Officer felt that having this information would have been helpful.

Prison Officers D and E, who had received the information about Mr Mawhinney's letter on 28 December 2018, were concerned about him. They went to his cell, had a

conversation with him and ensured that he knew he could come forward and ask for support should he need it. He was also in the company of friends. These Prison Officers responded appropriately by having a meaningful conversation with Mr Mawhinney and assessing his mood.

While there was commentary about Mr Mawhinney being visibly upset on the landing on 28 December 2018 not everyone agrees and there is no CCTV evidence to support the claim. At interview, two Prison Officers referenced recording information such as the letter Mr Mawhinney had received that day. Senior Prison Officer T said knowing of the letter would have been significant and Prison Officer U said the Prisoner Record and Inmate System Management (PRISM)[11] could be put to much better use and it would have also been helpful to know that Mr Mawhinney had previously attempted suicide outside prison. The new SPAR Evo process, and in particular the addition of a digital approach in June 2019, allows for records such as these to be kept and to be accessible to those on the landing but a note in the landing journal would have been useful as indicated by Prison Officers T and U.

There appears to be no clear way of signalling to Prison Officers how events from previous experience within the prison setting or from knowledge within healthcare can influence how someone in custody behaves and reacts. This applies particularly when someone has a significant history of self-harm and, in Mr Mawhinney's case, a PD diagnosis. This is of concern to me. One potential means of sharing knowledge about what impacts the mood of an individual in custody or triggers emotional turmoil and sometimes what can be construed as 'bad' behaviour, is through an individual's Safer Custody Profile. The SPAR record is another. Steps need to be taken to find ways for information known to Prison Healthcare to be shared with the Prison Service and for the Prison Service, in their turn, to consider how to disseminate such information effectively. I am aware of current arrangements and efforts to share risk information. However, this will need constant monitoring until the balance is struck in terms of effectiveness, not only for mental ill health, but for other circumstances in which a person in custody may have behavioural issues that may result in disciplinary procedures and potentially mean the behavioural issues will not be addressed as they could be. I therefore recommend:

Recommendation 2: Sharing information with Prison Service Staff

The Trust and Prison Service should review how information is provided to staff on the landings to ensure they are fully aware of what is required to provide effective support to each individual in custody. This should include how to clearly record information about triggers and stressors.

5.8 Questions raised by Mr Mawhinney's family

Mr Mawhinney's family asked some probing questions about matters that relate to what were potential stressors for Mr Mawhinney. Their questions relate to stress, breakdown in relationships and loss of contact with family. They asked:

- About the content and impact of the letter Mr Mawhinney received
- About Mr Mawhinney's access to the telephone

Mr Mawhinney's family asked about the content and impact of the letter he received on 28 December 2018. Understanding the impact of the letter relates to what I have discussed in the previous section with regard to stressors but also to Mr Mawhinney's access to support on the day of receipt of the letter and on the following day.

Mr Mawhinney relied greatly on the telephone. On 28 December 2018 he made some 12 phone calls. I can find no evidence of phone calls on 29 December 2018. Given that the landing was locked for a large part of that day it is unlikely that Mr Mawhinney would have had access to the telephone. My investigator has viewed CCTV and can verify the last telephone call Mr Mawhinney can be seen making was on 28 December 2018 at 18:22. This corroborates the records I have received from the Prison Service. My investigator saw no evidence of a telephone call on 29 December 2018 and prison records show no calls on that day. Neither is there evidence of Mr Mawhinney wanting to make a phone call on the 29 December 2018. Mr Mawhinney did attend church on 29 December 2018 and while his landing was unlocked for a short time when the evening meal arrived no one would have been permitted to use the telephone given the circumstances. The whole of H2 was locked from mid-afternoon due to another incident.

The content of the letter Mr Mawhinney received has been variously described as I have discussed in Section 4.5. The letter itself will be submitted to the inquest and considered there. Mr Mawhinney described it in different ways. He spoke of how it impacted him when he said he had been 'kicked to the kerb' and he expressed concern about his relationship with one of his children because of the letter. He had spoken to one of his children on 28 December 2018. This account demonstrates the letter was indeed a trigger as the family question suggests.

In terms of other stressors Mr Mawhinney's family raised a question about the time he spent in the CSU. I have set out the circumstances of his time in the CSU in Sections 4.3 and 5.6. I do not consider that this was a particular stressor for Mr Mawhinney.

The family asked about an incident that had occurred when Mr Mawhinney had been charged with verbally abusing a Prison Officer and they asked if there had been any

potential impact on his death. Following a second meeting with the family I was able to get clearer information about what incident they were referring to as described in Section 5.5. As I concluded there, the incident is unlikely to have had any impact on Mr Mawhinney's death as it had occurred in July 2018 while he was in Maghaberry Prison.

1.	**The content of the 'Dear John' letter and any potential impact this had on Mr Mawhinney** The letter was written in response to a letter Mr Mawhinney had written to one of his children. It explained why the author felt they were not 'good together' and assured Mr Mawhinney this was not because there was someone else. It is clear from records and statements that Mr Mawhinney found the letter very difficult.
2.	**Background to Mr Mawhinney being in the CSU and if he was under threat from another inmate** Mr Mawhinney was moved to the CSU for his own safety (Section 4.3.) on 17 November 2018. Prison Officer R explained to him that he was not there as punishment but for his own safety. He left the CSU on 26 November 2018 when he moved to H2.
3.	**Background to an incident when he was charged with verbally abusing a Prison Officer and any potential impact on his death** A number of incidents occurred when Mr Mawhinney was charged with foul and abusive language. The last adjudication for such an incident took place on 04 September 2018 at Maghaberry Prison and is unlikely to have had any impact on his death. The incident the family referenced took place in July 2018 and is, therefore, unlikely to have had any impact on his death.

5.9 Findings

a. Recording and sharing information about stressors: I find that information about stressors was not readily available to landing staff at Magilligan Prison. They were not clearly marked on Mr Mawhinney's prison record to assist Prison Officers to make judgements about his behaviour and reactions. The development of SPAR Evo, the addition of digital support, the risk information sharing mechanism between the Trust and the Prison Service are all contributing to an improved environment on this matter. A finally agreed information sharing agreement will also be important. I strongly believe that more can and should be achieved. I have made a recommendation in Section 5.7 to enable the Prison Service and the Trust to review what information is available and how it is being shared to provide guidance and support to staff on landings.

b. **Opening and Recording Concerns**: I find that a Concern should have been opened when it became evident that Mr Mawhinney was upset following a letter received on 28 December 2018. The embedding of the SPAR Evo approach and the digital management of SPAR information will contribute to improvement on this matter and therefore I do not make a recommendation at this stage but will monitor progress with regard to SPAR Evo.

c. **Support Provided:** I find that Prison Officers and others on the landings offered support to Mr Mawhinney, that he had company over the two days before the incident on 29 December 2018 and that he was able to draw support via phone calls. On 29 December 2018 Mr Mawhinney engaged with others on the landing, attended church with three others, borrowed tobacco and was seen and heard talking to others. There are conflicting accounts of his behaviours on that day. It appears to me that there were no particular signs of what he was potentially planning for that evening. The clinical reviewer's opinion was that the death was not predictable. She did note that, in her view, Mr Mawhinney was 'always at risk of self-harm.' In a situation such as this it is important to address how increased risk can be assessed. I will address this in the following Section.

d. The use of the CSU for the safety of people in custody: In this instance I find that Mr Mawhinney's safety was paramount and a decision had to be taken about where best to place him for his own safety. The decision to move Mr Mawhinney to the CSU was an appropriate decision and Mr Mawhinney received the care expected while he was there.

e. Impact of adjudications: Some of the adjudications Mr Mawhinney experienced were due to volatile relationships with staff. Mr Mawhinney arrived at Magilligan Prison on 01 November 2018 and had no adjudications before the incident on 29 December 2018. He had adjudications while at Maghaberry Prison, some of which were about relationships with Prison Officers. Due to the length of time between those adjudications and events on 29 December 2018 it is unlikely these influenced what happened.

Section 6. The effectiveness of clinical care

6.1 Section introduction

As in the community, clinical healthcare in the prison setting must be provided in line with local and national policies and procedures. This section will consider policy and procedure and the overall effectiveness of the care provided to Mr Mawhinney in relation to his health. From the previous section it is clear that Mr Mawhinney had regular contact with healthcare generally and with mental healthcare in particular.

How Mr Mawhinney's needs were assessed and care provided is critical for an evaluation of the effectiveness of clinical care provided to him. It is also important to assess if there was equivalency of that care with what he would have received in the community given the constraints and pressures of life in custody. In addition to adherence to policy and procedure this section will, then, consider how the SPAR process was applied in Mr Mawhinney's case, if there were any root causes for his behaviour or risks that could or should have been identified. I will also consider developments in SPAR processes since Mr Mawhinney's death.

6.2 Application of the SPAR process

I have set out Mr Mawhinney's SPAR history in detail in Section 5.3. The clinical reviewer carefully reviewed all of Mr Mawhinney's SPAR documentation and concluded, 'these were opened appropriately and there was multidisciplinary presence at the reviews.' SPAR handling was, therefore, in line with the Prison Service *Suicide and Self-Harm Policy 2011, updated 2013*.

However, the clinical reviewer also noted that, 'the SPAR entries were generally superficial and the SPAR process reactive and what would have been useful was an overarching management plan based on a psychological formulation allowing for proactive SPAR opening, for example following life events like the letter he received on 28th.'

In light of her findings Professor Shaw recommended:

1. For those with multiple problems including personality disorder and previous self-harm, a full mental health history, case formulation and management plan should be developed to inform care. This should be shared with prison staff and likely high risk situations for self-harm identified.
2. There should be a review of SPAR processes with particular reference to improving the quality of reviews and monitoring by prison staff with more meaningful exploration of the factors leading to self-harm.

I have dealt with similar matters in previous reports. I note that since previous recommendations were made the SPAR procedures have been reviewed, updated and improved in SPAR Evo which I will discuss in Section 6.3. In Section 5.7 I addressed the information shared with prison staff, particularly those on the wing who interface with those living in custody on a daily basis. The matter of what Professor Shaw defines as a care formulation and management plan has been a recurring issue in my investigations. The underlying purpose of such an approach is to ensure that there is continuity of care for the individual concerned.

Effective continuity of care requires health information, information about stressors gathered from those giving on the ground support, support an individual has received in the past and commentary on how behaviours can indicate discontent, anxiety, unhappiness or other such strong and potentially overwhelming emotions so as to alert those caring for them. Care provided while in custody is then informed by this knowledge. Continuous care also includes that provided when someone is released back into the community. Professor Shaw particularly references how such information can be collated to provide a mechanism to identify situations when critical stressors could have an adverse impact and the information shared properly. There is no doubt that this is a challenging ask, not least because of information sharing constraints. Nevertheless, for the care of individuals in custody, this is a critical ask.

Overall I concur with the finding of Professor Shaw that SPARs were conducted appropriately. Professor Shaw's recommendations should be noted by the Trust and I suggest that her concerns are addressed during the external evaluation of SPAR Evo, as set out in the RQIA's *Review of the Care of Vulnerable Persons Detained in NI Prisons*.

6.3 Personality disorder, root causes and predictability of self-harm and suicide

The overall assessment provided by Professor Shaw is that:

> *'… there was no specific root cause and his death was not predictable. The introduction of an approach to the management of PD … could help prevent future similar deaths.'*

Mr Mawhinney had a diagnosis of dissociative personality disorder. Such a diagnosis should ideally form a significant aspect to continuing care. RQIA's *Review* addresses the need for specialist input for PD given its high prevalence in the prison setting which is identified as being in the region of two thirds of those in custody. PD is particularly difficult to respond to in a structured way. In Mr Mawhinney's case there was a clear diagnosis which could have been assessed in terms of impact on his behaviour given the difficulties that those with PD have regulating their emotions and the consequent behaviour challenges that are likely to follow.

PD is also known to increase the risk of suicidal behaviour. In a custody environment good behaviour is critical for regime progression and behaviour is a significant mechanism for assessing progression. If the impact of health conditions are not taken into account then it is possible that a person in custody could be unfairly judged as behaving badly. The RQIA Report notes that 'any effective intervention requires a co-ordinated effort…..supported by additional resource as necessary.' I am pleased to see a recognition that the prison environment should also be considered

in terms of how it might impact on those with a PD diagnosis. In this regard RQIA points to the value of PIPE – Psychologically Informed Planned Environments. I fully support the recommendation which is in line with the clinical review in Mr Mawhinney's case.[12]

6.4 From SPAR to SPAR Evolution

At the time Mr Mawhinney was moved to Magilligan Prison a new approach to the prevention of suicide and self-harm had been introduced. This would take some time to apply across all sites and it is notable that Mr Mawhinney is the first death in custody to have been managed on what is known as SPAR Evolution (SPAR Evo).

SPAR Evo was developed following a *Review of the Safety of Prisoners held by the Northern Ireland Prison Service* carried out by CJINI in 2014. In CJINI's report one of the key strategic recommendations was that a review of the SPAR policy should take place in conjunction with the Trust. The Prison Service response was to put a healthcare lead in place with direction to deliver all the recommendations in the CJINI report. The older SPAR process had been rightly aimed at keeping individuals in custody safe. The new SPAR Evo focussed on moving procedures from being process driven to being people-centred so that procedures applied would take account of each individual's needs in a more productive and meaningful way. A number of limitations were noted in the older, process-driven SPAR approach, including acknowledgement that:

- Observation cells and safety clothing had become the default with little real improvement for or focus on the subject of the decision
- The numbers of people placed on SPARs at any one time diluted the attention staff could devote to individuals
- The procedure was paper-based with streamlined information held digitally meaning only the staff member holding the SPAR booklet had a full overview

Additionally, a number of recommendations had been made to the Prison Service regarding SPAR processes from my Office and CJINI reports.

[12] RQIA *Review of the Care of Vulnerable Persons Detained in NI Prisons* recommendation 4 page 23*:* Commissioners (currently the HSCB) and providers (SEHSCT) should work together to plan, commission and implement a therapeutic approach to personality disorder within the prison service. This should include the introduction of a specialist personality disorder service providing evidence-based treatment programmes. Commissioners (currently the HSCB) and providers (SEHSCT) should also work together with NIPS to consider the introduction of Psychologically Informed Planned Environments to help improve the management of people with personality disorder.

In conjunction with colleagues from the Trust, the Prison Service Healthcare lead developed a new people-centred model, operational procedures, required documentation and ultimately a new IT solution incorporating mobile technology which would mean staff were more informed about individuals in their care. A proof of concept was implemented in Magilligan Prison from 30 April 2018 to 20 July 2018 and feedback gathered from Prison Service and Trust staff, other organisations on site and people in custody and amendments to the process were made. SPAR Evo, the name reflecting how the process was evolving, was formally signed off between the Prison Service and the Trust on 05 April 2019. Roll-out continued at Magilligan Prison and a staged roll-out was agreed across all other prisons completing in August 2020.

It is important to note some key features of SPAR Evo which are distinct from those applied previously during a SPAR:

I. **A person-centred, multi-disciplinary approach.** While SPARs were commended for multi-disciplinary case conferences the important shift was the person-centred approach

II. **The use of Concern Forms, now a digitally recorded Concern**. The older SPAR process required a Prison Officer and Mental Health team member to open the SPAR. SPAR Evo allows anyone to raise a concern including staff, other individuals in custody and family members. When raising a concern a wide range of issues are now considered, as opposed to a checklist of issues, including background and history, what the individual is saying about their situation, asking about protective factors and suicide, consideration of contributory risks and making a determination about the degree or level of risk

III. **Assessing risk.** The older SPAR process had simply assessed an individual as being either at risk or not, requiring a SPAR or not. SPAR Evo, taking the broader and person-centre approach, offers three possible outcomes flowing from the Concern Form:

- No apparent risk: requires no further action at the point in time when the Concern Form is completed but importantly a formal record is in place of the discussion, what issues were considered and how the determination of no apparent risk was reached. This record did not exist under the older SPAR process
- No apparent risk with referral or other action: no immediate risk of suicide or self-harm but some additional support during the time of crisis or distress is required. The IT solution allows for these referrals to be made without delay, for example to mental health or for bereavement support. This

response means that an individual in custody does not have to move cells into an observation cell, as they might have had to under the older SPAR, nor do they have to wait for referrals to be made.

- At risk: a care plan is put in place based on need and designed to address the root cause of the distress or crisis and support the individual through it. As far as possible, individuals remain in their own cell and carry on with activities with the focus on engagement and contact in a meaningful way. This is a different focus from the older SPAR which would have placed the individual into an observation cell or maintained them in their own cell but without normal activities.

One of the emphases of the new SPAR Evo is on meaningful conversations, an important emphasis confirming the person-centred approach

IV. **A new IT solution**. Concerns are now opened on a tablet on which the full history is available to the person completing the form. Colour coding allows staff to interpret information swiftly and include this in their considerations.

While the new SPAR Evo has yet to be evaluated the shift in emphasis is obvious. This is a significant and important development for supporting people in custody. The encouragement to engage directly with the individual who is potentially at risk is also significant and can contribute to increased trust. Information gathered from evaluations will be critical to informing future approaches and it is important that such information is collated in the manner proposed by RQIA to inform the assessment of need.[13] I am keen to see better use of data to inform practice and keen that the effectiveness of data gathering is reviewed and analysed, I am also conscious of the resource constraints and the current demands placed on those caring for people in custody, in particular arising from the work of RQIA. I am not, therefore, making a further recommendation in relation to reviewing how effective data is being gathered, collated and used to inform care at this time but I am clear that the current demands placed on those providing care for people in custody are both right and proportionate to need. I have no doubt that some who, like Mr Mawhinney, have conditions difficult to identify, manage and communicate, can get lost within the system.

[13] **Recommendation 12 (Priority 2):** Commissioners (currently the HSCB) and providers (SEHSCT) should ensure that there is a robust screening and data collection system for specific vulnerabilities such as learning disability, autism, ADHD, acquired brain injury and dementia. This data should be used to inform the needs assessment, planning and commissioning of specialist provision to ensure that services meet the needs of these vulnerable groups. (p36f)

6.5 Findings

a. Effective clinical care: Overall I find that the clinical care provided to Mr Mawhinney was effective.

b. SPAR and SPAR Evo: SPARS were appropriately opened and managed and the move to SPAR Evo is significant. Evaluation should be completed without delay to ensure improvements can be made to SPAR Evo and effectively delivered to those individuals who are in custody.

c. Stressors: The matter of identifying and communicating information about stressors for individuals in custody remains a critical concern.

Section 7. Responses to events on 29 December 2018

7.1 Section Introduction

In the moments following a serious incident the actions of those individuals present are critical. Their actions are influenced by their knowledge and experience of policies and procedures and from that perspective each policy and procedure is important. Application of policy and procedure should be scrutinised to gather learning for the future. Both Prison Service and Trust staff play a pivotal role in these critical moments post-incident. In this section I will set out what the responses were and identify both concerns and instances of good practice if and where they occurred. I will address some of the family's questions in this section:

- How long and appropriate resuscitation was, including how long Mr Mawhinney went without oxygen
- If any explanation other than attempted hanging could be provided for Mr Mawhinney's transfer to hospital
- What evidence of hanging is available

7.2 Immediate responses: Prison Service and Prison Healthcare

When Prison Officer H found Mr Mawhinney hanging he immediately raised a Code Blue, setting a chain of events in motion. The Emergency Control Room (ECR) was alerted to call an ambulance and healthcare were informed. Prison Officer H quickly enlisted the assistance of 2 other Prison Officers and together they supported and lowered Mr Mawhinney to the ground where they appropriately commenced CPR. Nurse C arrived on the scene approximately 3 minutes after the Code Blue and

recorded that CPR had commenced. Nurse C administered naloxone twice but it had no effect.

Prison Officer J left the scene to bring the defibrillator and CPR continued until the first paramedics arrived at around 20:00 when further naloxone was administered and a faint pulse detected. On advice of the paramedics, Mr Mawhinney was taken to hospital at 20:51 hours. I have included a timeline of events at Appendix 3.

For a serious incident, such as this one, healthcare initiate a Serious Incident Review which I will discuss further in Section 7.5.

When Mr Mawhinney was taken to hospital the incident was reported to the PSNI, the Duty Governor, Governor D, was informed, the cell was properly sealed and the action recorded. These actions were in line with procedure. My Investigating Officer received notification of the incident the next morning. However, a serious incident referral was not made to my Office which brings to light an area of work to be carried out between my Office and the Prison Service to enable the timely gathering of evidence. This work is currently underway. In Mr Mawhinney's case I have no concerns about the security of evidence as the cell was locked and sealed.

7.3 Immediate information sharing

At each individual prison a process is in place to ensure that a number of people are informed when a serious incident occurs. It is important that there is no avoidable delay to this process particularly as a number of steps must be completed before the family are informed.

a. **The Duty Governor and Senior Governors**. On the evening of 29 December 2018 the Duty Governor, Governor D was informed of the incident at 21:44. Governor D then attempted to contact the Senior Governor on call, Governor E, as set out in the procedure. Some issues with contact occurred which I will discuss in Section 8.5 for learning purposes. I am satisfied that this did not cause undue delay in getting information to Mr Mawhinney's family.

b. **The Family.** Inevitably a family will feel that the news about their loved one should have come to them much more quickly than it did. The focus must always be on saving the life of an individual and it is only when everything has been done for the individual in distress that other actions are taken. In this instance, there was some work to be done as Mr Mawhinney's former partner was listed as the legal next of kin. Issues were expedited as quickly as possible and the family were informed at 22:35. Family immediately phoned medical staff for information and arrived at the hospital at 00:37 on 30 December 2018.

c. **The Trust.** The Trust began a Serious Incident Review in January 2019 and they contacted the family. On 04 February 2019 my on-call investigator received a call to inform the Office that Mr Mawhinney had died. A death in custody investigation was immediately initiated. Listening to the family sharing their experience of those early days there was significant confusion for them about different investigations, who was carrying them out and what their purpose was. This is understandable as they were processing unexpected and difficult news about Mr Mawhinney.

7.4 Prison Service post-incident actions and decision-making

When Mr Mawhinney was taken to hospital on the evening of 29 December 2018 he was accompanied by 3 Prison Officers, which is procedure. These Prison Officers maintained a steady bedwatch and a comprehensive record was kept. In previous reports, I have referenced the fact that at times conversations with family members can lead to misperceptions about events that have taken place or confusion when details of events have not been confirmed and in 2015[14] I made a recommendation for guidance to be issued to Prison Officers regarding visitor queries. Mr Mawhinney's family had a number of questions arising from conversations with Prison Officers on bedwatch. I will, therefore, recommend that guidance is reviewed, updated and reissued where appropriate to help avoid misperceptions and confusion.

It is important that a family has confidence that their loved one was known and properly cared for while in custody. One way of demonstrating this is for appropriate ongoing support and concern to be offered to them in the aftermath of a serious incident. In Mr Mawhinney's case this was particularly important as he remained sedated and unwell over a number of weeks before he died. During those weeks a number of Governors visited the hospital and spoke with the family. In previous reports I have recommended more responsive family contact arrangements. Recognising the stressful time an illness or death in custody is I now recommend that consideration be given to a named contact, or contacts, who would be the primary mechanism for communication with a family. This would address difficulties for families in knowing who to communicate with and give them the opportunity to build trust with a limited, known number of individuals. It is difficult to retain new information at a time of stress. It is important to say that there has been considerable improvement when an individual in custody is in hospital. In some instances a single point of contact would be of value because an individual is unwell while still in custody and regular family updates would provide some comfort and knowledge to a family separated from their loved ones. In the Mawhinney family's situation, it was important that a number of Governors visited the hospital and spoke with them but

[14] Report of Investigation into the death of Mr Joseph Rainey, published 03 February 2015

it was also difficult for them to keep up-to-date with every new individual who was communicating important information to them. An identified point of contact, with appropriate back-up to ensure contact is not delayed during leave or because of shift patterns, would have helped them during those difficult weeks and particularly in the early days of Mr Mawhinney's time in hospital. In this, as in other investigations, families have spoken of their confusion when it seems to them they have received different information from different officers. Additional guidance to anyone on bedwatch duty would, therefore, also be helpful. In light of the experience families have had I recommend:

Recommendation 3: Family contact

The Prison Service should consider appointing a named contact (or contacts) for families where there is protracted illness or when death has occurred and that guidance for Prison Officers on bedwatch duties be reviewed, updated and reissued.

On 31 December 2018 Governors dealing with Mr Mawhinney's case took the decision to release him under Prison Rule 27.2 which meant that the family could have some privacy at the bedside of their loved one. The Rule was applied from 18:00 on 31 December 2018, the family were informed in advance and the decision making process was in order. I am content that the Prison Service took this decision at the earliest possible time and that staff were withdrawn appropriately.

7.5 Questions raised by Mr Mawhinney's family

Outstanding questions from Mr Mawhinney's family relating to matters immediately following the incident on 29 December 2018.

1.	**How long and appropriate resuscitation was, including how long Mr Mawhinney went without oxygen** When Mr Mawhinney was found and lowered to the ground, CPR began. It is impossible to establish exactly how long Mr Mawhinney had been without oxygen. Evidence suggests that he had been speaking with his neighbour through the window between 5 and 10 minutes before he was found. As it was impossible to know how long Mr Mawhinney had been without oxygen it was appropriate to begin CPR.
2.	**If any explanation other than attempted hanging could be provided for Mr Mawhinney's transfer to hospital**

	Nurse C noted in healthcare records that there were ligature marks on Mr Mawhinney's neck. Records and statements indicate that Mr Mawhinney was found hanging, was lowered to the floor and CPR commenced. The post-mortem concluded that the cause of Mr Mawhinney's death was 'hypoxic ischemic necrosis of the brain and pneumonia due to hanging.' No explanation other than hanging has been discovered during my investigation. It is for the Coroner to finally make a ruling on cause of death.
3.	**What evidence of hanging is available** Mr Mawhinney's family felt that there were no marks on his neck when they saw him and therefore no indicators of an alleged hanging. They expressed a suspicion that he had not attempted to hang himself but rather had been attacked. Witness statement evidence from Prison Officers provide accounts of Mr Mawhinney hanging by a ligature from his cell window. The first healthcare worker to arrive at Mr Mawhinney's cell on the evening, after he had been lowered to the floor, was Nurse C. In her written report of the incident she records that there were 'visible ligature marks on his neck.' The post mortem report states the cause of death as hypoxic ischaemic necrosis of the brain and pneumonia due to hanging and notes reddening behind the ears which may have been caused by a ligature. The evidence found in Mr Mawhinney's cell, listed at Section 4.7, following the incident on 29 December 2018 also suggests a possible intention to self-harm.

7.6 Findings

a. Support for the family and good practice responses: I have reviewed the responses of the various agencies when Mr Mawhinney was found on the evening of 29 December 2018, including information sharing between agencies and between agencies and the family. I am satisfied that approaches were taken that were supportive of the family while ensuring good practice.

b. The possibility of a different explanation for Mr Mawhinney's death: Mr Mawhinney's family have asked questions about evidence of hanging, any other explanation for Mr Mawhinney having to go to hospital, the impact of the letter Mr Mawhinney received and his relationships with others in custody and with Prison Officers. It is likely that they are concerned about whether or not what happened to Mr Mawhinney was self-harm and if it was, whether or not it was intended. The loose documents found in Mr Mawhinney's cell, a number of which were letters to loved ones, may suggest he had intent. This is a matter for the Coroner.

PART B: LEARNING

Section 8. Learning and good practice

8.1 Section introduction

One of the purposes of my investigations is to ensure learning from past experience to improve practice in the future. During the course of an investigation a considerable amount of information is gathered from written documentation, CCTV, interviews, landing journals, inmate notes and healthcare records. It is important that good practice is noted to ensure it continues into the future and that, where practice has not been all that it could have been, improvements can be applied. Such learning should enhance process, procedure and the experience of those involved with a death in custody. A number of important learnings have been identified during the course of my investigation into Mr Mawhinney's death.

8.2 Arrangements for individuals in custody who experience seizures

While in custody Mr Mawhinney began to have identifiable seizures which were responded to appropriately. At the time of his death a picture was still being built of how seizures affected him. Anyone subject to seizures should not, for their own safety, be sleeping in a top bunk.

On 11 November 2018 healthcare were called to Mr Mawhinney's cell at Magilligan Prison. He appeared to have fallen from the top bunk and there was a query about whether or not he had a seizure. In the Trust's *Significant Event Audit* they noted this had occurred and that he had a history of seizures. Improvements have been made since Mr Mawhinney's death and the Trust is applying an approach that involves sharing identified risk information using a manually shared and emailed template that allows Prison Officers immediate access to information, which can be added to PRISM. It is unclear to me the degree to which this practice has been successfully implemented. I therefore recommend that it be reviewed.

Recommendation 4: Sharing risk information

The Prison Service and Trust should review how information related to the risk of suicide or self-harm is shared to ensure Prison Officers have the information they need to respond appropriately to individuals in custody and their behaviours.

On 06 December 2018 a further report of a seizure came from Mr Mawhinney himself. The previous evening Nurse C was distributing medication and noted that he appeared tired and had reported that he thought he might have had a seizure. The conversation of 06 December 2018 is properly recorded but no observations appear to have been taken. None were recorded. A further conversation about what had happened the previous evening, between Nurse D and Mr Mawhinney, took place on 07 December 2018. The Trust's *Significant Event Audit* notes these conversations and emphasises that good practice would have been to carry out and record observations. This matter has been addressed within healthcare practice.

I note that learning lines were issued to staff to ensure that the Prison Service are advised that where individuals in custody experience seizures they should be accommodated in a bottom bunk and that observations should be taken and recorded post-seizure.

8.3 Monitoring Mental Health Waiting Lists

Mr Mawhinney had a number of mental health concerns for which he was properly referred for support. However, while in Maghaberry Prison Mr Mawhinney had waited some time for follow up referrals. I welcome work done by the Trust to make information about waiting times available particularly where the individual in custody is not key-worked by the Mental Health team. This matter is also addressed in the RQIA report which notes the proposed New Regional Electronic Health Records System (ENCOMPASS) system that will allow for management of all waiting lists, including mental health. The RQIA Report notes that it will be some time until the ENCOMPASS system is in place and the need for an interim solution. I endorse this approach and commend the Trust who have identified and commenced use of a system that can be put to work in the short term. However, I am also aware of the considerable strain on resources and the underfunding of Healthcare in Prisons as noted in the RQIA Report.

8.4 Following up on matters identified at Hot and Cold Debriefs

At the hot debrief a matter was raised and follow up action was agreed to be taken by Nurse E. This did not happen. Nurse E was not present at the hot or cold debriefs and it would appear that no one followed this up. I am content that processes for ensuring actions at debriefs are followed up are now in place.

8.5 Processes for contacting Senior Governors post-Incident

On 29 December 2018 at 21:44 the Duty Governor, Governor D, was informed about what had happened to Mr Mawhinney. Governor D then attempted to contact a Senior Governor on call as set out in the procedure. Some issues with contact occurred which I have mentioned in Section 7.3. I am satisfied there was no undue

delay in getting information to Mr Mawhinney's family and I commend the Duty Governor for the initiative taken. Procedures at Magilligan Prison have since been reviewed. I have had sight of the procedure and am satisfied that there is clarity about how it works.

8.6 The importance of follow-up conversations

On a number of occasions, particularly at Magilligan Prison, follow up conversations took place with Mr Mawhinney when disruptive or difficult events occurred. These are examples of good practice that should be noted by staff as making a difference to individuals in custody. For example, on the morning following a possible seizure event on 06 December 2018 the Nurse had a conversation with Mr Mawhinney about his possible seizure to increase learning about how seizures could affect him. On the day Mr Mawhinney received the upsetting letter, 28 December 2018, those Prison Officers who were made aware about the letter and its impact made their way to Mr Mawhinney's cell to check-in and make sure he knew further support was available should he request it.

8.7 Supporting other individuals in custody

Those in custody on H2 D-Wing landing were aware of Mr Mawhinney's circumstances regarding his family and when he received the letter on 28 December 2018 they made themselves available to him and approached staff to make sure they understood the letter had impacted Mr Mawhinney. They further checked-in on him on 29 December 2018. This example of good practice amongst people on landings is worthy of note in an environment where individuals in custody can often feel alone.

Section 9: Conclusions

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

1.	To establish a chronology of events, specifically leading up to the time when Mr Mawhinney was found in his cell and taken to hospital, including a timeline of responses until his death.
	I have established, from written records and statements, a chronology of events leading up to the incident on 29 December 2018. The timeline included in Section 4 and at Appendix 3 has been cross-referenced for accuracy.
2.	To establish the existence and significance of stressors present for Mr Mawhinney leading up to the time of events of 29 December 2018, how they

	were identified and how they were responded to, particularly as he had a history of self-harm.
	Significant stressors did exist for Mr Mawhinney but knowledge was not joined up to ensure the provision of information that could assist Prison Officers' alertness to types of behaviours Mr Mawhinney could display. In this instance I do not find that such knowledge would have made a difference to the relational response Mr Mawhinney received on 28 December 2018 nor would the opening of a Concern Form have likely led to any further response.
3.	To examine the effectiveness of the clinical care provided to Mr Mawhinney.
	Overall I am satisfied that the clinical care provided to Mr Mawhinney was adequate. He had regular medication reviews, saw a psychiatrist and was referred appropriately for additional support. However, there was some delay to his referrals as has been noted in the review of events carried out by the Trust.
4.	To identify any learning for the future.
	I have noted learning already actioned by the Trust: arrangements for individuals in custody who experience seizures and monitoring mental health waiting lists. I have identified the following areas of learning and good practice: • Following up on matters identified at Hot and Cold Debriefs. • Procedures for contacting senior governors post-incident. • The importance of follow-up conversations with individuals in custody who have experienced challenging or stressful events or who have been identified as feeling stressed. • The importance of individuals in custody supporting each other

I have a further duty to 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 a clinical review of healthcare in the case of Mr Gavin Mawhinney

To review the medical and healthcare records, Prison Service records and Prisoner Ombudsman's investigative records related to Mr Mawhinney and produce a report giving clinical opinion. The review should:

- Examine the provision of clinical care and treatment, including both risk assessment and risk management, including where input from or interface with other care providers may influence the outcome for the patient (this should include a review of the resuscitation of Mr Mawhinney)
- Examine any secondary care provided (to the extent necessary for the review)
- Provide a chronology of the health and social care events leading up to the incident and include in that chronology events that influenced the incident
- Identify any care or service delivery failings along with the factors that contributed to these problems
- Examine policy and practice
- Identify any root causes that inform the identification of learning opportunities
- Make timely, clear and sustainable recommendations for the prison health care provider and prison service
- Provide explanations and insight for relatives of the deceased

Key questions for the clinical reviewer:

- How and when did the prisoner die?
- Any root cause of the death?
- Was the clinical care equivalent to the community?
- Are there learning opportunities for the care provider?
- Were local and national policies and procedures adhered to?
- Is it possible to say with certainty if Mr Mawhinney's death could have been predicted or prevented?
- Is there an opportunity to prevent future deaths in similar circumstances?
- Are there examples of good practice?

Appendix 2: 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 3: Timeline of Events 28-31 December 2018

28 December 2018	
Morning	Mr Mawhinney received letter.
11:00 approx.	Letter shown to 2 Prison Officers by other individuals in custody who explained Mr Mawhinney was upset. Mr Mawhinney spoke with a Prison Officer about football bets.
11:06	Mr Mawhinney made a phone call (author of letter 1.24 minutes).
11:08	Mr Mawhinney made a phone call (not answered).
11:10-11:20 approx.	Two Prison Officers go to Cell 45 to speak to Mr Mawhinney.
11:49	Mr Mawhinney made a phone call (not answered).
11:50	Mr Mawhinney made a phone call (1.17 minutes).
12:30-13:30	Concert in Mr Mawhinney's Inmate diary. He did not attend.
12:30	Lunchtime landing lock.
14:00	Landing unlock.
14:41	Mr Mawhinney made a phone call (7.11 minutes).
14:49	Mr Mawhinney made a phone call (not answered).
14:50	Mr Mawhinney made a phone call (3.46 minutes).
14:51	Mr Mawhinney made a phone call (not answered).
15:07	Mr Mawhinney made a phone call (mother 3.05 minutes).
15:11	Mr Mawhinney made a phone call (mother 5.51 minutes).
18:22	Mr Mawhinney made a phone call (friend 2.29 minutes).

18:30	Night time lock.
29 December 2018	
Before 10:00	Supervised swallow completed.
	Another individual in custody went to see Mr Mawhinney in his cell after unlock. I have been unable to corroborate the time.
12:30	Lunchtime lock.
14:10	Landing unlock.
14:20-16:00 approx.	Landings in H2 C and D locked due to incident requiring an ambulance to be called. Two Prison Officers accompanied the individual concerned to hospital. Landings remained locked and Prison Officers from the CSU attended to assist with evening meal.
14:50	Mr Mawhinney activated his alarm and asked if he could attend church. He and 3 others went out to church and returned to the landing about 15:17.
16:00	D-Wing unlocked for evening meal and for individuals to get hot water.
16:25	Another individual in custody activated alarm and asked Prison Officer to take Mr Mawhinney tobacco which he did.
16:40	Wing in night guard mode.
19:20 – 19:33 approx.	Mr Mawhinney talking to another individual in custody, Individual C, through the window.
19:30 approx.	Start of shift headcount begins.
19:33	Code Blue raised as Mr Mawhinney found unresponsive. Prison Officer seeks assistance from 2 other Prison Officers, unlocked cell, placed Mr Mawhinney on the ground and commenced CPR.
19:35	Prison Healthcare received call and went to landing immediately.

19:36	Nurse C arrived on landing, assisted with CPR, inserted nasal airway.
19:50	Nurse C administered naloxone in leg muscle.
19:55	Nurse C administered second dose of naloxone.
19:58	First paramedic on the landing. Administered further 3 doses of naloxone. No response.
20:09	Second paramedic on landing. Mr Mawhinney increased effort to breath, pulse improving, appeared to be stabilising.
20:25	Ambulance arrived. Mr Mawhinney began to deteriorate.
20:34	Mr Mawhinney taken to outside hospital.
21:00	Staff informed Mr Mawhinney arrived at Causeway Hospital. Prison Officer K phones PSNI to inform about incident.
21:44	Duty Governor, Governor D, informed of incident by Prison Officer K.
21:49	Duty Governor, Governor D, informed Governor F.
21:54	Cell sealed. Locked by Prison Officer H, witnessed by Prison Officer M.
21:55	Mr Mawhinney was ventilated with breathing tube & catheterised.
22:00	Hospital ask prison staff to contact Next of Kin.
22:05	Mr Mawhinney transferred for Computerised Tomography (CT) scan and returned to A&E Department at 22:30 to be kept sedated and assessed at 08:00 the following morning.
22:35	Next of kin informed. They phoned medical staff, 22:38 (Next of kin was recorded as former partner. This was changed to appropriate family member 22:45).
23:40	Mr Mawhinney moved to ICU.
30 December 2018	
00:37	Family members speak to doctors in ICU and with Mr Mawhinney at bedside overnight.
08:20	Governor D made contact with Governor E who took control of the situation.

	During the day an unsuccessful attempt was made to reduce Mr Mawhinney's medication and the family remained by his bedside. The priest and a Governor visited.
31 December 2018	
	Mr Mawhinney showed little change throughout the day. His family were with him, the chaplain and 2 Governors visited.
16:00	Bedwatch staff received a call from Governor A to let them know that Mr Mawhinney would be placed on Rule 27.2 as of 18:00. This would give the family more privacy.
18:00	Bedwatch staff withdrew.

Mr Mawhinney remained at Causeway Hospital until 04 January 2019 when he was moved to Antrim Area Hospital to wait for a bed in neurology at the RVH. He was moved there the following day, 05 January. Sadly Mr Mawhinney remained at the RVH until his death on 04 February 2019.