Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Wayne Hurren, a prisoner at HMP Wormwood Scrubs, on 16 March 2019

A report by the Prisons and Probation Ombudsman

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Our vision

To carry out independent investigations to make custody and community supervision safer and fairer

Our values

We are:

Impartial: we do not take sides

Respectful: we are considerate and courteous

Inclusive: we value diversity

Dedicated: we are determined and focused

Fair: we are honest and act with integrity

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

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Wayne Hurren was found dead in his cell on 16 March 2019 after he cut his throat at HMP Wormwood Scrubs. He died of hypovolaemic shock, caused by a significant loss of blood. He was 57 years old. I offer my condolences to his family and friends.

I am satisfied that Mr Hurren received appropriate physical and mental health care at Wormwood Scrubs. He did not give any indication that he was at imminent risk of suicide or self-harm and had not been monitored under the prison's suicide and self-harm procedures since November 2017. I consider that staff could not reasonably have anticipated his actions.

However, I am concerned that roll checks were not properly completed the night and the morning before Mr Hurren was found dead in his cell. I cannot say whether this might have affected the outcome for Mr Hurren.

There was a delay in entering Mr Hurren's cell because he had barricaded it, and staff could not find the anti-barricade key. This delay would not have changed the outcome for Mr Hurren who had clearly been dead for some time when he was found, but it could make a difference in other cases.

I am also concerned that healthcare staff tried to resuscitate Mr Hurren despite the presence of rigor mortis.

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

Elizabeth Moody
Deputy Prisons and Probation Ombudsman **November 2019**

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Summary

Events

1. On 2 June 2017, Mr Wayne Hurren was remanded to HMP Wormwood Scrubs. It was not his first time in prison. Staff recorded that he had depression and schizophrenia (for which he was prescribed medication) and a history of substance misuse and self-harm (although he had not harmed himself recently).

2. After Mr Hurren's initial health screen and during his early days in prison, staff reported that he displayed bizarre behaviour and often made strange comments about his criminal past and family. He was referred to the mental health team and was prescribed antidepressants and antipsychotic medication. A prison psychiatrist, psychologist and the mental health team regularly saw Mr Hurren.

3. The mental health team noted that once Mr Hurren had settled in prison, he generally did not display any of the strange behaviours that he had previously exhibited. However, on several occasions, he displayed poor behaviour (for example, he set small fires in his cell, smashed his cell door observation panel and was abusive to staff) to trigger a transfer to the segregation unit, where he said that he felt calmer and safer because of the small size of the unit.

4. From December 2018, Mr Hurren regularly complained of pain and blood in his stools and urine. His medical records show that he was treated for haemorrhoids and thrush.

5. A roll check, including a check on prisoners' welfare, was not completed on the evening of 15 March or the morning of 16 March.

6. At 8.52am on the morning of 16 March, an officer unlocked Mr Hurren's cell door. Mr Hurren had barricaded his cell door with furniture and there was a delay of eight minutes before staff could get into his cell because they could not find the anti-barricade key which allows the door to open outwards. During this time, staff noted that Mr Hurren was unresponsive but not fully visible through a gap in the door. An officer radioed a medical emergency code and the control room called an ambulance immediately.

7. When the barricade was removed, staff found Mr Hurren with rigor mortis (meaning he had been dead for some time) but tried to resuscitate him. Paramedics arrived very quickly and immediately assessed that Mr Hurren had died. They confirmed his death at 9.05am.

8. The post-mortem examination established that Mr Hurren died of hypovolaemic shock caused by blood loss as a result of deep cuts to the neck.

Findings

Assessment of risk

9. We are satisfied that staff properly assessed Mr Hurren and that there was nothing to indicate that he was at high risk of suicide or self-harm at the time of his death.

Roll checks

10. The night duty member of staff failed to conduct the evening roll check on 15 March and the morning roll check on 16 March 2019 as he should have and therefore did not check on Mr Hurren's welfare. Although we cannot say whether this might have made a difference in Mr Hurren's case, early intervention in other circumstances might save a life.

Response to barricade

11. There was a short delay of about eight minutes in staff entering Mr Hurren's cell after he barricaded the cell door with his furniture because staff could not find the anti-barricade key. While this delay did not affect the outcome for Mr Hurren as he was found with rigor mortis, such a delay could be critical in future cases.

Resuscitation

12. While we understand that staff wanted to save Mr Hurren's life, rigor mortis was present. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. Healthcare staff should therefore not have tried to resuscitate him.

Recommendations

- The Governor should ensure that roll checks are properly carried out.
- The Governor should ensure that staff know how to deal with barricade incidents and that anti-barricade equipment is readily available.
- The Head of Healthcare should ensure that staff understand when cardiopulmonary resuscitation should not be started.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Wormwood Scrubs informing them of the investigation and asking anyone with relevant information to contact him. One prisoner contacted him.

14. The investigator visited Wormwood Scrubs on 21 March 2019. He obtained copies of relevant extracts from Mr Hurren's prison and medical records.

15. NHS England commissioned a clinical reviewer to review Mr Hurren's clinical care at the prison. The clinical reviewer carried out the clinical review on their behalf. The investigator and clinical reviewer interviewed 16 members of staff, some jointly, and one prisoner at Wormwood Scrubs during the investigation.

16. We informed HM Coroner for Western London District of the investigation and have sent the Coroner a copy of this report.

17. One of the Ombudsman's family liaison officers contacted Mr Hurren's family to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They asked if Mr Hurren had asked to speak to a Listener the night before his death and wanted to know when the night duty staff had last checked him. They also pointed out that a prisoner had phoned them from a mobile phone and told them of Mr Hurren's death. We have considered these issues in this report.

18. Mr Hurren's family received a copy of the draft report. The solicitor representing them wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the family.

Background Information

HMP Wormwood Scrubs

19. HMP Wormwood Scrubs is a local prison in West London which can hold nearly 1,300 men. The prison holds men on remand from West London courts and London prisoners serving short sentences or coming to the end of long sentences. Care UK is contracted to provide primary care and several other health services at Wormwood Scrubs. In August 2018, Wormwood Scrubs was selected to be part of the "10 Prisons Project" which seeks to improve safety, security and decency in the prisons involved. The project is focusing on reducing violence, improving living conditions, preventing drugs from entering the prison and enhancing the leadership and training available to staff.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Wormwood Scrubs was in July and August 2017. Inspectors reported that the management of prisoners in crisis was poor and in too many cases, insufficient action was taken to promote prisoners' safety. Inspectors found that care for prisoners vulnerable to self-harm was inadequate.

Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to May 2018, the IMB reported its concerns that the supply of drugs continued to be a major problem for the prison and that tackling this had been hampered by a lack of resources. However, they noted that an increase in the numbers of prison officers had had a clear positive effect on the day-to-day functioning of the prison.

Previous deaths at HMP Wormwood Scrubs

22. Mr Hurren was the fifteenth prisoner to die at Wormwood Scrubs since November 2015 and the seventh prisoner to take his own life. We have previously made recommendations about the management of ACCT procedures.

Assessment, Care in Custody and Teamwork

23. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide and self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which

accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

24. On 2 June 2017, Mr Wayne Hurren was remanded to HMP Wormwood Scrubs, charged with the possession of an imitation firearm with intent to cause fear of violence. It was not his first time in prison.

25. A nurse completed Mr Hurren's initial health screen and noted that he had depression, schizophrenia and a history of substance misuse and self-harm (although he had not harmed himself recently). Mr Hurren arrived in prison with procyclidine (a drug to counteract the involuntary movements caused by antipsychotic drugs) and fluoxetine (an antidepressant). She referred Mr Hurren to the mental health team.

26. A prison GP saw Mr Hurren and recorded that he had paranoid schizophrenia, for which he prescribed fluoxetine and procyclidine and referred Mr Hurren to the mental health team for assessment. Mr Hurren said that he had no current thoughts of suicide or self-harm.

27. On 5 June, a nurse from the mental health team completed an initial assessment for Mr Hurren and noted that Mr Hurren made some bizarre comments, including that he had recently given birth.

28. She obtained information about him from the community mental health team, including that he had a history of paranoid schizophrenia and did not consistently take his medication. Mr Hurren had said that he had not taken his depot modecate injection (a long-acting injection of an antipsychotic medication) for several months. However, the community mental health team confirmed that this was not true and that Mr Hurren had had the injection two weeks earlier but had missed the medication for two to three months before that. She referred Mr Hurren's case for discussion at the weekly multidisciplinary mental health review team meeting and referred him for a mental health assessment.

29. On 7 June, a consultant forensic psychiatrist chaired the weekly multidisciplinary mental health team meeting. The review panel agreed to continue to monitor Mr Hurren and to hold a care programme approach (CPA) meeting with remote input from the community mental health clinicians.

30. Staff gave Mr Hurren a disciplinary warning on two occasions during June after he smashed his cell door observation panel. Staff also reported that he had displayed bizarre, hostile and angry behaviour. On one occasion, Mr Hurren refused to return to his cell, had packed his personal belongings and wanted to be moved to the segregation unit. Staff spoke to Mr Hurren and eventually persuaded him to return to his cell. A prison forensic psychiatrist tried to see Mr Hurren on 12 June, but this was not possible as Mr Hurren was at a disciplinary hearing.

31. The prison forensic psychiatrist reviewed Mr Hurren on 21 June but noted no change in his mental state. He planned to discuss him at the multidisciplinary MDT.

32. A nurse saw Mr Hurren on 23 June and administered his depot modecate injection.

33. On 29 June, the multidisciplinary team meeting discussed Mr Hurren and formulated a care plan, including assessing and monitoring Mr Hurren regularly for any signs of a recurrence of psychotic illness. At this stage, although Mr Hurren

made bizarre claims and exhibited some unusual behaviour, he was not assessed as acutely unwell.

34. On 7 July, an independent consultant forensic psychiatrist assessed Mr Hurren at the request of the courts. The psychiatrist noted that Mr Hurren suggested that he should be transferred to a mental health hospital.

35. The prison forensic psychiatrist reviewed Mr Hurren on 10 July and noted that he appeared 'okay' and had interacted positively with his peers. Mr Hurren said that he had a court hearing soon and believed he would receive a long sentence. He asked for his depot injection dose to be increased as he thought he was mentally ill but later said that he did not need it as he felt well. He noted that Mr Hurren displayed no signs of psychosis and had no thoughts of suicide or self-harm. He questioned whether Mr Hurren wanted to be moved to a mental health unit before his forthcoming court hearing.

36. Staff recorded that Mr Hurren had pressed his emergency cell bell numerous times on the evening of 15 July to have conversations with staff.

37. A consultant forensic psychiatrist saw Mr Hurren on 17 July and noted that he had expressed a number of ideas which might indicate that he had an underlying mental illness. He suspected that Mr Hurren was keen to portray features of mental illness and frequently referred to his need for antipsychotic medication. He noted that the mental health team would continue to monitor Mr Hurren.

38. When a nurse saw Mr Hurren on 21 July, she noted that he was in a good mood. Wing staff had told her that Mr Hurren continued to display bizarre behaviour intermittently. The nurse gave Mr Hurren his modecate depot injection.

39. On 28 July, the consultant forensic psychiatrist assessed Mr Hurren after an assessment by an independent consultant forensic psychiatrist. He noted that Mr Hurren continued to take his medication. Mr Hurren talked about his long criminal history, family and friends and said that he had spent time in a psychiatric hospital. Afterwards he discussed Mr Hurren with his community mental health care co-ordinator, who had known Mr Hurren for five years and who said that he had never presented with psychotic symptoms. He noted that he was not convinced that Mr Hurren had had a relapse of paranoid schizophrenia and sought further information from the psychiatric hospital. (This information was never received.)

40. On 2 August, Mr Hurren set his cell door observation panel on fire. The next day, he apologised to staff for his behaviour. Two days later, he was abusive towards staff.

41. On 7 August, staff found that Mr Hurren had makeshift weapons and he was placed on the basic level of the Incentives and Earned Privileges (IEP) scheme for 14 days. (The IEP scheme is designed to encourage good behaviour and challenge misbehaviour.) Later that day, Mr Hurren set fire to his observation panel because he had not received his canteen (orders from the prison shop). Staff explained that this was because he had exceeded his spend limit.

42. A psychiatrist and a nurse assessed Mr Hurren's mental health on 8 August. The psychiatrist noted that Mr Hurren displayed no evidence of depression or psychosis and was fit to stand trial.

43. The next day, staff moved Mr Hurren to the segregation unit because he had set fire to his cell and used threatening language towards staff. A nurse assessed that he did not need any medical treatment. The nurse gave Mr Hurren his medication (procyclidine) as he had not taken it that day.

44. When a nurse saw Mr Hurren on 10 August, he said that he was doing well in the segregation unit. He said that wing staff would not listen to him. He denied plans to harm himself. Segregation staff noted that they found Mr Hurren's comments bizarre at times.

45. On 16 August, the mental health team held a care programme approach review meeting. Mr Hurren and his community mental health care manager attended. Mr Hurren's mood was noted as 'bright'.

46. On 18 August, Mr Hurren told a member of the healthcare team that he was happy with his depot injection medication. He said that it had improved his sleeping habits and memory.

47. Mr Hurren returned to C Wing on 25 August. That day, a nurse from the mental health team saw Mr Hurren after wing staff raised concerns. Mr Hurren had reported that he had killed 163 people and served over 30 years in prison. He said that he had poisoned his father, mother and stepfather to stop them from suffering because they had degenerative diseases and were dying. He denied that he had any thoughts of harming himself or anyone else. The nurse noted that Mr Hurren appeared to display "grand delusional ideations".

48. On 27 August, Mr Hurren damaged his cell and demanded to be taken to the segregation unit. Staff also started ACCT procedures as Mr Hurren had made cuts to his chest and had given staff a note that said that he intended to take his own life. He refused medical treatment. A nurse assessed that he was fit for the segregation unit and he was moved there. Mr Hurren said that he wanted to be in the segregation unit because he was not coping on C Wing as it was too big for him. He said that he felt safer in the smaller environment of the segregation unit and had spent much of his time in prison in segregation units. He also wanted his depot injection medication dose increased.

49. On 30 August, a nurse updated the weekly multidisciplinary mental health team meeting on his recent contact with Mr Hurren and noted that Mr Hurren continued to talk about killing family members but did not display any psychotic symptoms.

50. On 31 August, segregation unit staff noted that Mr Hurren's behaviour was strange, including writing letters which did not make sense, making threats to kill people and claiming that he had killed his mother and father seven years earlier. Mr Hurren appeared calmer after he spoke to staff.

51. While in the segregation unit, staff (including governor grades, members of the chaplaincy team and healthcare staff) reviewed Mr Hurren daily to check on his wellbeing in line with segregation procedures. Staff reported that Mr Hurren adhered to the segregation regime and remained polite.

52. On 2 September, Mr Hurren told staff that he did not intend to take his medication. Staff noted that Mr Hurren often had delusions.

53. On 4 September, a prison forensic psychiatrist saw Mr Hurren. Mr Hurren threatened to harm himself if he was not prescribed drug therapy for attention deficit hyperactive disorder (ADHD) and post-traumatic stress disorder (PTSD). He said that he did not want his depot injection as he did not want to become dependent on them. The prison forensic psychiatrist noted that Mr Hurren's thinking was not disordered and that his behaviour was due to a personality disorder rather than acute mental illness.

54. On 8 September, Mr Hurren told segregation and healthcare staff that he had decided to stop taking his medication. On 11 September, Mr Hurren refused to return to C Wing from the segregation unit.

55. On 15 September, a member of the mental health team gave Mr Hurren his depot injection.

56. On 16 September, staff completed an ACCT review and noted that Mr Hurren engaged well. Mr Hurren reported that his sleeping and memory had improved and his depot injection had stabilized his mood.

57. On 21 September, the consultant forensic psychiatrist reviewed Mr Hurren who said that he felt safer in the segregation unit. Staff had reported that while Mr Hurren was disruptive at times on the wing, he kept his cell in the segregation unit immaculate and was courteous towards staff. He noted that Mr Hurren did not display evidence of psychosis or mania and did not say that he wanted to take his life or harm himself or others. Staff stopped ACCT monitoring on 27 September.

58. On 2 October, Mr Hurren returned to C Wing. A nurse reviewed him on 16 October and administered his depot injection. The nurse referred Mr Hurren for counselling at his request.

59. On the evening of 18 November, staff started ACCT procedures after Mr Hurren set fire to paper in his cell. Mr Hurren said that he wanted to see a governor and the prison GP (about his medication) and wanted to be moved to the segregation unit. He said that his depot injection medication was not working.

60. A nurse saw Mr Hurren on 20 November. He complained that his medication was not working and had been waiting for a mental health referral. He also said he had not been paid for his prison job for three weeks. He wanted to join some education classes and the nurse noted that wing staff agreed to look into it for him. The nurse noted that the consultant forensic psychiatrist had been told about Mr Hurren's medication concerns and agreed to discuss it at the weekly meeting. Mr Hurren thanked staff for listening to him and said that he had only started the fire to get some attention and for his needs to be met.

61. At his ACCT review on 27 November, Mr Hurren told staff that his medication issues had been resolved and he did not intend to harm himself. Staff stopped ACCT monitoring.

62. On 12 December, a nurse saw Mr Hurren. The review took place through his cell door as staff had reported that Mr Hurren had threatened to harm officers and set fire to his cell. He had already smashed the observation panel. Mr Hurren said that he was annoyed because his medication had still not been reviewed. He was scheduled to appear in court soon. A nurse made an appointment for Mr Hurren to

see the consultant forensic psychiatrist. She also gave Mr Hurren his depot injection.

63. When the consultant forensic psychiatrist saw Mr Hurren on 22 December, he noted that Mr Hurren's mental health appeared stable and he did not express thoughts of suicide or self-harm. Mr Hurren told him that he was next due in court in early January 2018.

Events from January 2018

64. On 8 January, a doctor from the Psychology Inreach Therapies Team saw Mr Hurren to explain therapy support.

65. On 9 and 11 January, Mr Hurren refused his depot injection and wanted his medication to be reviewed.

66. The consultant forensic psychiatrist saw Mr Hurren on 15 January to discuss a medication review. Mr Hurren said that the depot injection was not helping and that he had side effects. He noted that Mr Hurren did not display evidence of psychotic symptoms. However, Mr Hurren then said that he wanted to continue having a depot injection.

67. On 16 January, a doctor from the Psychology Inreach Therapies saw Mr Hurren again to continue assessing his mental health.

68. On 17 January, the multidisciplinary mental health team discussed Mr Hurren and his medication. When a nurse tried to give Mr Hurren his depot medication on 18 January, he again refused take it.

69. On 25 January, Mr Hurren was moved to the segregation unit after his behaviour was threatening, he smashed his observation panel and flooded his cell. The prison forensic psychiatrist reviewed Mr Hurren who said that he felt at home in the segregation unit. He noted that his mood was good, and he had no suicidal, delusional or depressive thoughts. He acknowledged the stress that Mr Hurren was under as his court case was ongoing and noted that the mental health team would monitor him. Mr Hurren continued to refuse his depot medication.

70. On 15 February, staff moved Mr Hurren to E Wing. On 19 February, the doctor from the Psychology Inreach Therapies Team saw Mr Hurren to continue with his psychological therapy. Mr Hurren declined to participate and said that he would prefer to continue with the therapy support after he had been sentenced.

71. On 5 March, the consultant forensic psychiatrist saw Mr Hurren who refused to take his depot medication but wanted to be prescribed pregabalin (medication for anxiety, epilepsy and neuropathic pain which is often traded illicitly in prison) for trauma. The consultant forensic psychiatrist declined to prescribe this and encouraged Mr Hurren to engage with the doctor from the Psychology Inreach Therapies Team.

72. On 10 March, staff issued Mr Hurren with a disciplinary warning after he smashed his observation panel. Mr Hurren later spoke to a Listener. A prison manager asked for Mr Hurren to have a mental health review as he had asked for medication and did not seem his usual self. A prison GP tried to see Mr Hurren but he would

not engage with him. On 14 March, staff again issued a disciplinary warning to Mr Hurren for being abusive towards them. His IEP level was reduced to basic and his television was removed from his cell. (Mr Hurren returned to standard IEP on 24 March.)

73. On 9 April, a nurse reviewed Mr Hurren. She noted that he was cheerful and had remembered some coping strategies and started meditating again which helped.

74. The doctor from the Psychology Inreach Therapies Team saw Mr Hurren on 11 April as part of his psychological therapy support. After the review, he noted that Mr Hurren had relayed a complex history of trauma and violence in his life that had affected his long-term mental health. He noted that Mr Hurren appeared to meet many of the criteria for PTSD and Mr Hurren agreed to complete 12 sessions of psychological therapy.

75. A member of the chaplaincy team spoke to Mr Hurren on 17 April and 23 April and had lengthy conversations about his life. Mr Hurren said he welcomed the support.

76. On 25 April, Mr Hurren attended court, and was sentenced to eight years and four months in prison. A prison GP saw him when he returned from court and he said that he was fine.

77. The doctor from the Psychology Inreach Therapies Team completed Mr Hurren's psychological therapy sessions on 9, 14 and 21 May and 4 June.

78. A nurse reviewed Mr Hurren on 5 June. He said that he was doing well, was still employed and had good family support. A nurse saw Mr Hurren on 15 June and noted that he exhibited no signs of psychosis. Mr Hurren accepted his depot injection medication.

79. On 3 July, the doctor from the Psychology Inreach Therapies Team saw Mr Hurren after three weeks. Mr Hurren said that he had recently been moved to E Wing and felt settled, calmer and was able to manage his emotions better than on C Wing. He said that he had used the Listener service on the wing and agreed to therapy support. Mr Hurren said he had no thoughts of suicide or self-harm. (He saw Mr Hurren again on 16 and 30 July, 6, 20 and 28 August and 17 September.)

80. On 13 July, Mr Hurren refused his depot medication. When a nurse saw him on 19 July, he accepted his depot injection, and said that that his psychology sessions had helped. The nurse noted that Mr Hurren displayed no psychotic symptoms or thoughts of suicide or self-harm.

81. On 26 July, Mr Hurren told staff that he had been self-medicating with heroin because his medication was not working. He was referred to the substance misuse and mental health teams.

82. On 2 August, Mr Hurren started a job as a cleaner. On the same day, he told wing staff that he was unhappy with his medication. Wing staff passed this information to the mental health team. A member of the healthcare team reviewed Mr Hurren's medical record, noted that he had not attended the medication hatch to collect his antidepressants and informed the mental health team. A lead consultant psychiatrist tried to see Mr Hurren on E Wing the next day, but he was unavailable.

83. The lead consultant psychiatrist saw Mr Hurren on 7 August. She noted that he expressed paranoid beliefs and was unclear what had triggered his distress. She noted that he would be reviewed at the weekly meeting. Mr Hurren said that he felt unwell when he took the depot injection and wanted to feel "normal" again. She agreed to stop his prescription for depot injections and procyclidine and consider the alternatives. She also asked for Mr Hurren to be tested for drugs.

84. The next day, the prison forensic psychiatrist chaired the weekly mental health team meeting, and the lead consultant psychiatrist discussed Mr Hurren. It was noted that Mr Hurren did not appear psychotic and the mental health team would continue to monitor him and refer him for therapy.

85. Mr Hurren attended an occupational therapy group session five times in August and September.

86. A nurse reviewed Mr Hurren on 24 August. Mr Hurren said that all was going well and that he was seeing a psychiatrist.

87. In September, Mr Hurren refused to attend an interview with his offender manager to discuss his sentence plan. On 21 September, a nurse reviewed Mr Hurren who said that he was overwhelmed with work, the therapy groups and the psychology input. He asked not to attend the groups for three weeks.

88. The doctor from the Psychology Inreach Therapies Team tried to complete his last psychological therapy session with Mr Hurren on 1 October but Mr Hurren declined to attend. Staff had told him that Mr Hurren had asked to be prescribed his depot injection medication again. He told a nurse.

89. On 30 October, the prison forensic psychiatrist and a nurse assessed Mr Hurren. Mr Hurren said that he felt lethargic and had had muscular pains for a month. He denied using illicit substances. He said that he had not been able to work as he was tired in the mornings. He felt that his depot injection would rejuvenate him. They decided not to restart his depot medication because Mr Hurren's mental health was stable, he displayed no psychotic symptoms, looked well and had no thoughts of suicide or self-harm. They arranged for a prison GP to complete a variety of blood tests to check for an underlying cause for Mr Hurren's lethargy and agreed that the mental health team should continue to monitor him.

90. The results of the blood tests were found to be normal, with a slightly raised white blood cell count which suggested a possible mild infection. Healthcare staff noted that no action was needed.

91. On 19 November, a nurse saw Mr Hurren who said that he remained excessively tired and was not sleeping well at night which had affected his attendance at work and group therapy. He said he had pains in his hands and a burning sensation when defecating, as well as several spots on his legs. The nurse told Mr Hurren that she would refer him to the prison GP. Mr Hurren said that he believed his symptoms were a result of his body "crying out for the depot injection".

92. On 4 December, a nurse saw Mr Hurren who complained of headaches and that he was constipated. The nurse examined Mr Hurren, gave him paracetamol, advised him to drink fluids and referred him to the prison GP. A nurse saw Mr Hurren on 10 December when he again complained of being constipated. The nurse prescribed

painkillers and a prison GP subsequently prescribed Mr Hurren lactose (for his constipation).

93. On 24 December, a nurse saw Mr Hurren who said that he was still tired.

Events from January 2019

94. On 7 January, a nurse saw Mr Hurren who said that he was not currently prescribed antipsychotic medication and felt that his mental health was good. He said that he had a new job as a yard cleaner. However, he complained that he had pains in his body and was constipated (which he linked to not taking depot injections). The nurse told Mr Hurren to speak to healthcare staff about his constipation because she noted that he had recently been prescribed laxatives.

95. Mr Hurren failed to attend a scheduled GP appointment to discuss his physical health on 15 January. No reason was recorded.

96. On 16 January, the lead consultant psychiatrist chaired the weekly multidisciplinary meeting. A nurse updated the team about Mr Hurren and noted that he no longer wished to attend therapy groups.

97. A nurse saw Mr Hurren on 28 January. Mr Hurren said that he remained constipated and in the last two days, he said that he had found lumps in his rectum which burnt when he passed urine. The nurse made an appointment for Mr Hurren to see the prison GP and completed some tests which were inconclusive and needed to be repeated.

98. On 30 January, Mr Hurren's partner phoned the prison as she was concerned about his health. Staff told her that he had a GP appointment scheduled for that week.

99. A security intelligence report on 2 February noted that Mr Hurren had told staff that he had blood in his urine and blood coming from his rectum. Mr Hurren had said that he was thinking of hurting himself so that he could go to hospital. He said that he was in pain and felt that he was not receiving the appropriate treatment, which made him feel like hurting himself. There is no evidence that this information was shared with the healthcare team.

100. The lead consultant psychiatrist tried to see Mr Hurren on the morning of 5 February, but she was unable to do so as he was on a visit. That day, healthcare staff arranged for Mr Hurren to have urine and stool tests.

101. On 6 February, the lead consultant psychiatrist chaired the mental health team's weekly multidisciplinary meeting, and a nurse discussed Mr Hurren.

102. Later that day, a prison GP saw Mr Hurren. Mr Hurren said that he had had constipation for four weeks and felt unwell. In the last two weeks, he said that blood had appeared in his urine, his "backside was on fire", he had a lump on his testicle which was tender and his kidneys were throbbing. He asked to be prescribed painkillers.

103. He examined Mr Hurren's abdomen (which was not tender) and testicles (which were tender). Mr Hurren declined a rectal examination. He told Mr Hurren to drink lots of fluids, noted that further tests would be completed and that he would review him again. He prescribed co-amoxicla (an antibiotic), ibuprofen (for pain relief) and

a laxative. He asked staff to take blood from Mr Hurren, including liver function tests and a prostate-specific antigen test.

104. On 12 February, an officer from the safer custody team met Mr Hurren who said that he wanted to be transferred to another prison. The officer said that he would forward his request to the offender management unit. Mr Hurren said that his antibiotics had improved his bladder infection. He said that he had paranoid schizophrenia and that the mental health team were supporting him. However, Mr Hurren said that he had chosen not to take his medication.

105. On 14 February, the safer custody team noted that they had received several phone calls from Mr Hurren's partner who was concerned about his physical health. The safer custody team passed this information to the healthcare team who confirmed that Mr Hurren was due to see the GP that day.

106. That evening, a nurse saw Mr Hurren who said that he needed a GP to examine his rectum as the lumps on his rectum had grown larger and were causing an obstruction. The nurse told the wing nurse.

107. On the morning of 15 February, staff reported that Mr Hurren had smashed his cell door observation panel and had thrown a brown liquid with a distinctive smell (which was believed to be faeces) onto the landing. Staff gave Mr Hurren a disciplinary warning and he was moved to the segregation unit. A nurse saw Mr Hurren when he arrived in the segregation unit. Mr Hurren told her that he had lots of lumps in his rectum. She noted that a prison GP had seen Mr Hurren on 6 February, but he had declined a rectal examination. She added Mr Hurren to the GP list for the following day. A nurse assessed that Mr Hurren was fit for the segregation unit.

108. A prison GP completed a rectal examination for Mr Hurren on 16 February. He found no evidence of hard lumps or a growth but diagnosed haemorrhoids which had caused the rectal bleeding. He also noted that Mr Hurren had penile candidiasis (thrush). He prescribed Mr Hurren antifungal creams and antibiotics. Mr Hurren also asked for something to help him sleep and he prescribed him promethazine (an anti-histamine with a sedative effect) for four nights.

109. Staff, including governors and the healthcare team, reviewed Mr Hurren daily and staff reported that he adhered to the segregation regime and remained polite.

110. On 18 February, Mr Hurren told a nurse that he was happy in the segregation unit and had behaved poorly because he was frustrated that he had to wait so long to see a GP.

111. Over the next couple of days, Mr Hurren told staff that he had needed time away from the wings and that his healthcare needs had been addressed in the segregation unit. He said that he felt much better.

112. Mr Hurren was moved to C Wing on 22 February. He failed to attend a healthcare appointment scheduled that day. On 23 February, healthcare staff completed a urine test which detected no blood in his urine. The next day, Mr Hurren complained to healthcare that he had rectal pain and was prescribed ibuprofen.

113. On 26 February, Mr Hurren again failed to attend a scheduled healthcare appointment. The next day, Mr Hurren complained to a nurse that he had blood in

his urine and stools. He said that wing staff planned to take him to see the reception GP that evening.

114. A prison GP examined Mr Hurren shortly afterwards. Mr Hurren complained of back, rectal and penile pain. He also said that he was not sleeping well. He examined Mr Hurren and concluded that he had haemorrhoids. He prescribed him a suppository, painkillers, zopiclone (a sleeping aid), lactose and clotrimazole cream (for skin infections). He made an appointment to complete a full rectal examination and sent a task to the wing nurses to collect urine and stool specimens from Mr Hurren.

115. After he saw him, staff reported that Mr Hurren refused to return to C Wing despite several orders. Staff eventually escorted Mr Hurren to the segregation unit, where staff, including governors and the healthcare team, checked on him daily.

116. The healthcare team took urine, blood and stool samples and monitored Mr Hurren's condition. Mr Hurren's blood test results were normal, did not identify an infection. His haemoglobin level was at the higher end of normal. (A low haemoglobin level would have indicated that Mr Hurren had had significant blood loss.)

117. On 5 March, during the normal segregation checks, staff recorded that Mr Hurren was agitated, refused to take his medication and would not communicate with them. Mr Hurren said that he would not talk to staff because he had still not had a full rectal examination. Staff told Mr Hurren that he would see the prison GP the next day.

118. Later that day, the Governor visited Mr Hurren. He told her that he was unhappy because he felt that his health needs were not being met. She encouraged Mr Hurren to speak to healthcare staff.

119. A prison GP examined Mr Hurren in his cell on 6 March. Mr Hurren said that he had pains across his abdomen but was relieved that his bowel problem had improved and the rectal bleeding had stopped. He felt nauseous but had not vomited and reported that his eating habits were 'okay'. He examined Mr Hurren and noted that he was stable and comfortable. A rectal examination showed no abnormalities. Mr Hurren only had skin tags (a growth of excess skin) and therefore a referral to hospital was not necessary. He prescribed Mr Hurren metoclopramide (anti-nausea medication) and mebeverine (used to alleviate stomach pain). He sent a task to the healthcare team to monitor Mr Hurren's health observations, urine, stools and weight.

120. On 7 March, healthcare staff examined Mr Hurren and completed urine and stool tests and asked for blood tests to be taken. Mr Hurren's weight was recorded as 91kg (14 stones 5lbs, an increase from 2017 when he weighed 85.5kg, 13 stones 6lbs). His blood test showed a normal haemoglobin level which did not suggest rectal bleeding. The stool and urine tests showed no evidence of infection and appeared normal.

121. On 9 March, a prison manager saw Mr Hurren during the segregation rounds and noted that he had just returned from a visit which went well. Mr Hurren was moved to D Wing later that day.

122. A nurse saw Mr Hurren on 13 March. Wing staff had reported that they were reluctant to let him leave his cell because he was irritable. Mr Hurren told the nurse that this was because he was in pain and he felt that no one cared. He said that he still had blood in his stools and urine and was unable to sleep. When the nurse offered to make an appointment for Mr Hurren to see the GP, he refused and said that he wanted to move to another prison. He said that he wanted to return to the segregation unit as he felt that he received better care there. However, this was not possible as the segregation unit was apparently full. Mr Hurren raised concerns about his partner who he said was unwell. The nurse told Mr Hurren that she would arrange for a review of his physical health and that he should speak to the nurses about pain relief medication.

123. That day, Mr Hurren damaged his cell door observation panel. An officer also submitted a security intelligence report which noted that Mr Hurren had given him a note at 5.00pm which stated that he knew staff names, numbers and addresses and that if they "mess with" his family, he would do the same.

Events on 15 March 2019

124. A prisoner who lived in the cell next to Mr Hurren, told the investigator that he saw Mr Hurren give away some of his personal belongings to other prisoners.

125. CCTV shows that between 1.09pm and 4.19pm, Mr Hurren pressed his emergency cell bell seven times. On most occasions, staff responded in less than five minutes. Staff recorded no entries of concern about Mr Hurren after these interactions.

126. CCTV shows that an officer responded to Mr Hurren's emergency cell bell at 4.22pm. The officer had a short conversation with Mr Hurren through his cell door before leaving.

127. A Custodial Manager (CM) and a Supervising Officer (SO) returned to Mr Hurren's cell at 4.26pm. The CM told us that an officer had told him that Mr Hurren had created a small barricade in his cell and did not want to speak to anyone. The CM looked through Mr Hurren's cell door observation panel and saw a small piece of furniture behind his cell door. The CM described it as a "blockage". He unlocked the cell door but only opened it a little as Mr Hurren did not want him to come into the cell although he was happy to speak to him. They spoke briefly and Mr Hurren said that he was 'okay' and that staff should tell the Governor that he would be going to the segregation unit the following day and intended to stay there for a short period. The CM said that Mr Hurren did not ask to see a Listener but asked for some writing paper (which he was given). The CM told us that he had no concerns about Mr Hurren.

128. CCTV shows that the SO arrived at Mr Hurren's cell at 4.48pm and tried to give him a plate of food. Mr Hurren said that he did not want it. At 5.17pm, the CM checked Mr Hurren again as he was leaving the prison at the end of his shift. Mr Hurren said that he was 'okay' and told the CM that he would see him the next day.

129. CCTV shows that Mr Hurren pressed his cell bell at 6.22pm. At 6.38pm, an officer responded. The officer told us that she did not work on the wing but had seen that Mr Hurren's cell bell light was on as she walked through the wing. She spoke to Mr Hurren through his cell door observation panel and he asked for his cell night light to be switched off. The officer turned off the light and left the wing.

130. At 7.57pm, an officer completed a roll check by checking that all prisoners were in their cells and that the cell doors were locked. He raised no concerns when checking Mr Hurren who said that he was okay.

131. An operational support grade (OSG) started his night duty shift at around 8.40pm. The OSG signed the residential night wing log to say that he had completed a roll check of the wing at 9.10pm. However, CCTV footage showed that he did not complete this task.

132. A prisoner told the investigator that at around 10.00pm, he heard a lot of banging noises and/or furniture being moved in Mr Hurren's cell and that the noise lasted for about an hour. During this time, the prisoner said that he banged on the wall to get Mr Hurren's attention and to check that he was okay. Mr Hurren reciprocated by banging on the wall which he interpreted as meaning that he was okay.

133. CCTV shows that the OSG walked along the wing landing at 10.04pm but that he did not check on any prisoners.

Events on Saturday 16 March 2019

134. The OSG signed the residential night wing log to say that he had completed a roll check of the wing at 5.10am. However, CCTV footage showed that he did not complete this task and the prisoner who had been awake at the time and looking through his cell door observation panel, confirmed that this was the case. The OSG finished his duty at around 7.38am as a SO arrived.

135. At around 8.50 am, two officers started unlocking some prisoners on D Wing so that they could collect their medication. An officer arrived at Mr Hurren's cell and opened his observation panel which was covered so that the officer could not see inside the cell. He unlocked and tried to open the cell door but it only opened a couple of inches as Mr Hurren had made a barricade behind it with cell furniture. The officer called Mr Hurren's name, but he did not respond. He looked through the gap in the doorway and saw part of Mr Hurren's hand under his bed, which was against the door. He also saw blood on the floor. The officer immediately shut the door and alerted the other officer. The two officers immediately alerted a SO and another officer, who were in the office on the landing, that they believed that a prisoner had self-harmed by cutting himself.

136. The SO and an officer arrived at Mr Hurren's cell in seconds. The SO looked through the gap in the doorway and immediately radioed a medical emergency code red (to indicate that a prisoner is bleeding) and a code blue (to indicate that a prisoner is unconscious or has difficulty breathing). This was recorded in the prison control room log as occurring at 8.52am. The ambulance log shows that an ambulance was called at the same time.

137. An officer said that he saw through the gap in the door that Mr Hurren had positioned the furniture (bed and cabinet) to block the cell door. As more staff responded to the emergency, they tried to force the door open but it only opened a little further. The Head of Safety and two CMs also responded to the emergency. An officer and a CM said that they could see that Mr Hurren was lying on the floor, his arms were raised, pointing in the air and were stiff and pale. They told the investigator that there was a lot of blood on the floor and walls.

138. Three nurses arrived at the cell at around 8.53pm to find staff still trying to push the cell door open. The nurses unpacked their medical equipment, with a view to starting emergency care as soon as the cell door was opened.

139. A CM asked for the anti-barricade key to be brought to the cell. However, it was not in the usual place in the D Wing office and so staff had to look for one on another wing.

140. In the meantime, staff found a member of the works team who was on the wing and had a cordless drill. The workman used the drill to remove the screws on the hinge plates of Mr Hurren's cell door. A CM removed Mr Hurren's door and the furniture so that prison and nursing staff could go into the cell. CCTV shows that staff managed to get into the cell at 9.00am. The CM said that he saw Mr Hurren on the floor, his head was near to the toilet and his arms were in the air. There was a lot of dry blood. He saw that Mr Hurren had a very large and deep laceration to his neck, there was a lot of clutter in the cell and a broken toilet seat around him.

141. A nurse said that Mr Hurren was lying on his back, unresponsive and with his arms slightly raised. A nurse told us that Mr Hurren's arm and face were stiff. A nurse attempted to insert an airway into Mr Hurren's mouth but could not do so because his jaw was locked. Mr Hurren had a wound on his neck and was not breathing. There was lots of dried blood on Mr Hurren's throat, torso and abdomen, and in the cell. A nurse said that they started cardiopulmonary resuscitation (CPR) by doing chest compressions. A nurse applied a defibrillator which instructed staff to continue chest compressions.

142. Paramedics arrived at Mr Hurren's cell at 9.02am and took over his care. They examined Mr Hurren and immediately assessed that rigor mortis was present (meaning that Mr Hurren had been dead for at least two hours) and that he had a large laceration to his neck. They confirmed Mr Hurren's death at 9.05am.

Contact with Mr Hurren's family

143. At 12.48pm, Mr Hurren's partner (his listed next of kin), telephoned the prison and said that a prisoner had told her that Mr Hurren had taken his own life. The Head of Safety confirmed Mr Hurren's death, offered support and arranged to visit her that afternoon.

144. The Head of Safety and an officer visited Mr Hurren's partner and his family at 4.55pm. The prison contributed to the funeral costs, in line with national instructions.

Support for prisoners and staff

145. After Mr Hurren's death, the Head of Safety debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

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

Post-mortem report

147. The post-mortem examination established that Mr Hurren died of hypovolaemic shock caused by deep cuts to the neck. Mr Hurren had smashed the toilet seat in his cell and used this to cut his throat. (Hypovolaemic shock is a severe drop in the total amount of blood in the body. The heart cannot pump blood around the body unless a certain volume is present and this results in organ failure.)

148. Toxicology test results confirmed the presence of prescribed medications at therapeutic levels in Mr Hurren's system when he died. This included metoclopramide, paracetamol and fluoxetine. There was no evidence that Mr Hurren had taken any illicit substances before his death.

Findings

Assessment of Mr Hurren's risk

149. When Mr Hurren arrived at Wormwood Scrubs, staff appropriately identified and addressed his physical and mental health needs. He had a long history of mental health issues, including paranoid schizophrenia and depression, and was taking medication. He had last harmed himself in November 2017, 16 months before his death, when he had set fire to his cell. He said that it was because he had issues with his medication, wanted to see a governor and the prison GP and wanted to move to the segregation unit, where he felt he received better treatment. In this way, Mr Hurren at times appeared to use his behaviour to achieve what he wanted.

150. Three days before Mr Hurren's death, a mental health nurse saw him and noted that he complained about his physical health and wanted to be moved to the segregation unit. He expressed no thoughts of suicide or self-harm. The day before he died, he had numerous contacts with wing staff, including when staff talked to him about a small barricade that he had created behind his cell door with a view to achieving a move to the segregation unit. He did not express any thoughts of suicide or self-harm and staff were not concerned that that he was at risk of suicide or self-harm at the time. We do not consider that staff at Wormwood Scrubs could have foreseen that Mr Hurren intended to take his own life imminently.

Roll checks

151. Roll checks are carried out to ensure the security and integrity of the prison and enable to staff check on prisoners' welfare. An OSG signed a formal document to confirm that he had completed the roll check on the evening of 15 March and the morning of 16 March. However, CCTV footage shows that he had not done so. Falsifying documents is a serious disciplinary matter and we note that the OSG has subsequently been suspended from duty and is subject to disciplinary proceedings. While we cannot know whether the outcome for Mr Hurren might have been different if the OSG had conducted the roll checks as he should have, it might be critical in other circumstances. We therefore make the following recommendation:

The Governor should ensure that roll checks are properly carried out.

Response to the barricade incident

152. We found that there was a delay of eight minutes in staff going into Mr Hurren's cell because staff could not find the anti-barricade key. It is unlikely that this delay would have changed the outcome for Mr Hurren as rigor mortis was present but any delay in an emergency can be critical. We therefore make the following recommendation:

The Governor should ensure that staff know how to deal with barricade incidents and that anti-barricade equipment is readily available.

Clinical care

153. Mr Hurren frequently behaved poorly because he wanted to be in the segregation unit, often because he considered that healthcare staff would see him more quickly there.

154. The clinical reviewer noted that overall, the mental and physical healthcare that Mr Hurren received was equivalent to that which he could have expected to receive in the community. She found that the mental healthcare team reviewed Mr Hurren regularly and that he received good input from the prison consultant psychiatrist. During his stay at Wormwood Scrubs, Mr Hurren was not diagnosed with any symptoms of severe or enduring mental ill health.

155. She noted that when Mr Hurren presented with physical symptoms in the last three months of his life, healthcare staff responded, assessed and treated him appropriately.

Resuscitation

156. Prison and healthcare staff responded promptly to the medical emergency code on 16 March and called an ambulance for Mr Hurren.

157. Healthcare staff conducted CPR but told the investigator that Mr Hurren's face and arms were stiff, which indicated that rigor mortis was present. Rigor mortis normally sets in between two and six hours after death, meaning that Mr Hurren had been dead for some time when he was found.

158. We are concerned that nurses tried to resuscitate Mr Hurren when he had clearly died. The resuscitation attempt was undertaken by nurses who had all attended immediate life support (ILS) training and should have been aware of the European Resuscitation Council Guidelines 2015 which state, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile." The guidelines give examples of futility as including the presence of rigor mortis.

159. We understand the wish to continue resuscitation until death has been formally recognised but trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. The clinical reviewer noted that it was possible that the delay in entering Mr Hurren's cell caused the nurses to react without appropriate clinical reflection of their actions. While we do not suggest that additional resuscitation training is required, it is important that staff, especially the nurse who holds the emergency response radio, have the confidence to stop futile attempts to resuscitate. We make the following recommendation:

    The Head of Healthcare should ensure that staff understand when cardiopulmonary resuscitation should not be started.

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