Ms M E Hassell
HM Senior Coroner
Inner North London
St Pancras Coroners Court
Camley Street London
N1C 4PP

[redacted]

National Medical Director
NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

[redacted]

18 December 2024

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Wayne Anthony Bayley who died on 17 May 2022

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 31 October 2024 concerning the death of Wayne Anthony Bayley on 17 May 2022. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Wayne's family and loved ones. NHS England is keen to assure the family and the Coroner that the concerns raised about Wayne's care have been listened to and reflected upon.

I note you reference in your Report the extensive work that has already been undertaken by Practice Plus Group (PPG) at HMP Pentonville following this sad death, and I am reassured by this that lessons have been learnt.

I am pleased to note the collaborative working between healthcare providers and the prison with a focus on assessment, treatment, and medication of all prisoners, from healthcare planning on arrival into prison, through control and restraint, and entering a cell in an emergency. As you reference, this is particularly in the context of underlying health conditions and includes (but is not limited to) ensuring staff have a proper understanding of the identification of and risks associated with an acute sickle cell crisis.

Following Wayne's death, NHS England's regional Health and Justice Team conducted a period of engagement with staff and prison colleagues (2023), the findings from which resulted in liaison with the Sickle Cell Society who committed to providing training and development with prison staff across the London Health and Justice region, where there is a higher incidence of sickle cell.

This will include three elements:

1. Training and upskilling of healthcare staff
2. Training and upskilling of prison staff
3. Patient engagement

There will be an evaluation of this programme of training at the end of year one, but there is already a commitment to deliver the training for a period of three years.

Additionally, NHS England's regional Health and Justice team is working with NHS

England's Regional Nursing Directorate in London to pilot the 'ACT NOW'[1] sickle cell acronym in HMP Pentonville, with a view to rolling this out across other prisons in the London region. The 'ACT NOW' approach by the NHS is about supporting better care for patients across England, by encouraging clinicians to 'ACT NOW' whenever a patient attends hospital in a sickle cell crisis. Co-developed by clinicians, experts, people with sickle cell and their families, this approach supports a rapid and effective response to a sickle cell crisis in patients attending any hospital.

In relation to the matter of concern you direct towards NHS England nationally, that it is unclear whether the work identified as having been undertaken by PPG and HMP Pentonville has been replicated nationally, with improvements and learnings shared, I respond to this below.

NHS England is in the process of reviewing all current service specifications and I can assure you that the learning from this case will be used to strengthen this in relation to requirements around assessment and management of not only sickle cell anaemia, but all long-term conditions.

Additionally, a Health Needs Assessment (HNA) is undertaken annually in English prisons which reflects the diverse health needs of the population, including those with a long-term health condition, and informs local healthcare delivery plans.

Finally, Wayne's case will be presented to the Health and Justice Oversight Delivery Group (HJDOG) and shared with NHS England's regional commissioners. The action taken by the London region will also be shared with the HJDOG. HJDOG is the senior leadership forum, which holds responsibility for the oversight of delivery and continuous improvement in Health and Justice commissioned services, through both the national and regional teams, with a focus on improving health outcomes and reducing variation across England.

I would also like to provide further assurances on the national NHS England work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors, and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around events, such as the sad death of Wayne, are shared across the NHS at both a national and regional level and helps us to pay close attention to any emerging trends that may require further review and action.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,

[1] https://www.england.nhs.uk/london/a-c-t-n-o-w-sickle-cell-acronym-pilot/

National Medical Director