Regulation 28: Prevention of Future Deaths report

Wayne Anthony BAYLEY (died 17.05.22)

THIS REPORT IS BEING SENT TO:

1.

National Medical Director NHS England Wellington House 133-135 Waterloo Road London SE1 8UG

2.

Minister of State for Prisons Ministry of Justice 102 Petty France London SW1H 9AJ

1 CORONER

I am: Coroner ME Hassell

Senior Coroner Inner North London

St Pancras Coroner's Court

Camley Street London N1C 4PP

2 CORONER'S LEGAL POWERS

I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.

3 INVESTIGATION and INQUEST

On 25 May 2022, one of my assistant coroners, commenced an investigation into the death of Wayne Bayley, aged 43 years. The investigation concluded at the end of the inquest earlier today.

The jury made a narrative determination at inquest, which I attach. You will see that this includes a finding that death was contributed to by neglect.

4 | CIRCUMSTANCES OF THE DEATH

Mr Bayley died in HMP Pentonville, some ten hours after a restraint. His medical cause of death was:

- 1a acute chest syndrome
- 1b hypoxia and chronic sickle cell lung disease
- 1c sickle cell disease and restraint.

5 CORONER'S CONCERNS

During the course of the inquest, the evidence revealed matters giving rise to concern. In my opinion, there is a risk that future deaths will occur unless action is taken. In the circumstances, it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows.

In attempting to learn lessons from Mr Bayley's death, a great deal of work has been done by the primary healthcare provider in HMP Pentonville, Practice Plus Group, in liaison with the mental healthcare provider, Barnet Enfield & Haringey NHS Trust, and the prison itself.

This work has covered the assessment, treatment and medication of all prisoners, from healthcare planning on arrival in prison, through any control & restraint, to the entering of a cell in an emergency, all particularly in the context of any underlying health conditions – including, but not limited to, giving staff a proper understanding of the identification of and risks associated with an acute sickle cell crisis.

However, I am not at all clear that this work has been replicated nationally. Whilst PPG provides healthcare in 57 prisons, I understand that there are over double that number in England & Wales. I did hear evidence of the work of University College London Hospital in setting up an innovative outreach pilot. Nevertheless, my concern remains that learning and improvements in practice may not have been shared across the country.

6 ACTION SHOULD BE TAKEN

In my opinion, action should be taken to prevent future deaths and I believe that you have the power to take such action.

7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 27 December 2024. I, the coroner, may extend the period.

Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed.

8 | COPIES and PUBLICATION

I have sent a copy of my report to the following.

- and parents of Wayne Bayley
- HM Prison Pentonville
- Practice Plus Group
- Barnet Enfield & Haringey NHS Trust
- the Chief Coroner of England & Wales

I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest.

The Chief Coroner may publish either or both in a complete or redacted or summary form. She may send a copy of this report to any person who she believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response.

9	DATE	SIGNED BY SENIOR CORONER
9	DATE	SIGNED BY SENIOR CORONER

31.10.24 ME Hassell