Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Wayne Bayley, a prisoner at HMP Pentonville, on 17 May 2022

A report by the Prisons and Probation Ombudsman

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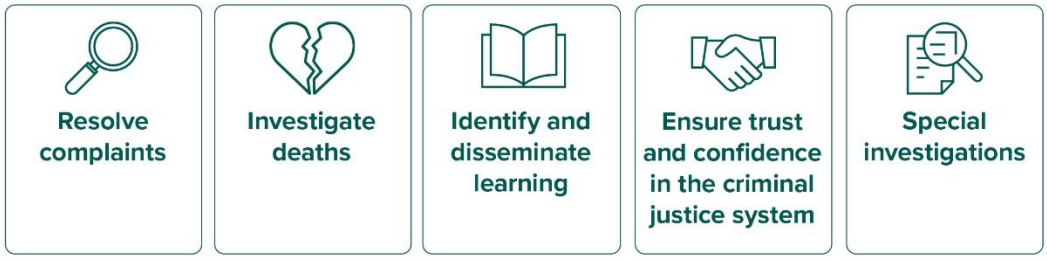
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Bayley, a black man, died from unascertained causes on 17 May 2022 at HMP Pentonville. He was 43 years old. I offer my condolences to Mr Bayley's family and friends.

Mr Bayley had sickle cell disease and epilepsy but was in apparently good health until he was subject to a use of force some ten hours before he was found dead in his cell. That my report runs to over twice as many pages as is usual for a natural cause death indicates the depth of my concern about what happened in those ten hours. This report makes for distressing reading. I am conscious that it will be especially difficult for Mr Bayley's family to absorb that force was used against Mr Bayley when that could have been avoided and from that point on, there were a series of critical missed opportunities to ensure that his health needs were being adequately met. These were founded in both ignorance and lack of professional curiosity and continued right up until he died. I believe that this was a preventable death.

I have made a number of recommendations including changes to national policy to make a difference to the assessment and segregation of prisoners subject to use of force and to promote awareness of sickle cell disease.

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

Adrian Usher
Prisons and Probation Ombudsman **October 2024**

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Summary

Events

1. Mr Bayley, a 43 year old black man, was remanded to HMP Pentonville on 11 May 2022. He had epilepsy and sickle cell anaemia. His medical records indicated he had been diagnosed with a delusional disorder and was prescribed anti-psychotic medication in 2018. It was not his first time in prison. On 16 May, after a period on the induction unit, Mr Bayley moved to cell G4-21.

2. At about 12.18pm on 17 May, Mr Bayley approached a member of staff on G Wing to complain about the condition of his cell. Two other officers joined them shortly afterwards. After five minutes discussion, two of the officers placed their hands on Mr Bayley to guide him to his cell and Mr Bayley resisted. The three officers used force to restrain him in a prone position and then walked him to the segregation unit using approved restraint techniques.

3. On the way to the segregation unit Mr Bayley collapsed to his knees. Mr Bayley declined to get up and staff picked him up using an incorrect carry technique. Mr Bayley complained he could not breathe and was placed in a seated position to regain his breath. Staff then carried him to the segregation unit using the correct technique. The nurse accompanying the group did not see Mr Bayley collapse.

4. Mr Bayley was deemed non-compliant with the regulation strip search and staff cut off his clothes. He was given clean clothes but did not dress himself. He was carried, naked and covered in a blanket, to a cell at about 12.37pm.

5. The nurse did not complete the initial assessment to determine whether Mr Bayley was fit to be segregated but segregation officers thought she planned to return later to do it. At about 2.00pm, the segregation unit supervising officer (SO) noticed faeces on the floor of Mr Bayley's cell. He had not dressed and was laying on the bed.

6. Mr Bayley remained naked in his cell and did not respond to officers' attempts to speak to him. Just before 4.00pm, the original nurse confirmed she was not going to complete the segregation health screen and that a mental health nurse should do it. The SO rang for the mental health nurse who concluded that Mr Bayley was not fit for segregation and thought he appeared mentally unwell. She arranged for Mr Bayley to be transferred to the inpatient unit (IPU), but a bed was not immediately available.

7. At about 7.30pm, Mr Bayley was escorted to the IPU. He looked frail and was unable to support his own weight, so staff moved him in an evacuation chair.

8. On arrival at the IPU, Mr Bayley told healthcare staff he could not breathe and asked for a doctor (who was in reception and was not called to see Mr Bayley). He sat on the floor in his cell and was thought to be asleep.

9. At about 10.30pm, night staff became concerned he was not breathing. They called a code blue emergency and paramedics attended. Prison staff and paramedics tried to resuscitate Mr Bayley, but he was pronounced dead at 11.46pm.

Findings

10. The initial use of force on Mr Bayley was not justified and the situation should have been dealt with by pausing to arrange a planned (rather than spontaneous) use of force.

11. The nurse that attended the use of force did not discharge her role to monitor and assess Mr Bayley during his removal to the segregation unit.

12. Those supervising Mr Bayley's removal to the segregation unit should have asked the nurse to assess Mr Bayley after he collapsed to his knees in E2 sterile area and after he told staff he could not breathe.

13. No one involved in the use of force considered whether Mr Bayley, a black prisoner, might have sickle cell disease as required by the guidance in place at the time (PSO 1600).

14. The initial segregation health screen was not completed within two hours as it should have been. The nurse failed to complete it and failed to communicate that she did not intend to do so, and the segregation unit staff did not escalate the situation after the two hours had elapsed. This led to an unnecessary delay in establishing that Mr Bayley was not fit for segregation and in moving him to the inpatient unit. There were a number of weaknesses in the segregation unit paperwork.

15. The initial segregation health screen is based on an algorithm that does not encourage staff to consider all relevant factors across the prisoner's mental and physical health. In particular, there is no mandatory requirement for staff to consult the prisoner's clinical record, take a set of physical observations or use standard tools to assess physical health such as NEWS2.

16. Not having a nurse present at the planned removal of Mr Bayley from the segregation unit to the inpatient unit was a missed opportunity for a healthcare professional to observe and assess Mr Bayley's physical condition.

17. The clinical reviewer concluded that Mr Bayley's clinical care was not of the required standard and noted a number of deficiencies in his care, including:

    - Despite having epilepsy and sickle cell anaemia he was not referred to the long-term conditions team.

    - Apart from visual observations, the nurse present at the use of force did not make any attempt to assess Mr Bayley's physical condition after he complained of breathing difficulties during his removal to the segregation unit.

    - Mr Bayley's condition was not adequately evaluated to determine whether he was fit and well enough to cope with a period of segregation and his clinical record was not consulted.

    - The nurse did not consider or try to establish whether there were physiological reasons why Mr Bayley was not responding to her questions.

- Mr Bayley's physical observations were not taken on arrival at the IPU, contrary to IPU operating procedures.

- From 9.00pm, Mr Bayley's visual observations were completed by an operational support grade without the clinicals skills to identify a deterioration in a prisoner's physical or mental health.

- Mr Bayley's medical records were not merged as they should have been when he arrived at the prison.

18. Mr Bayley's request to see a doctor was not properly explored or followed up.

19. Staff attending the use of force and the emergency response did not turn on their body worn video cameras as they should have done. This has been an ongoing issue at Pentonville.

20. Mr Bayley's cell on G Wing was not fit for occupation on 16 May 2022.

21. There was a four minute delay in summoning an ambulance and a further delay in the paramedics reaching Mr Bayley after the ambulance was directed to the wrong gate, but we do not think this affected the outcome for Mr Bayley.

Recommendations

- **The Head of Policy and Capability in the Security Directorate of HMPPS should amend the Use of Force Policy Framework to include the particular references to sickle cell disease that were contained in PSO 1600 and ensure that national use of force initial and refresher training includes information about sickle cell disease.**

- **The Governor of HMP Pentonville should implement the recommendations made in the NIMU report on the use of force against Mr Bayley within three months of this report.**

- **The Head of Security, Procedures and Capability in the Security Directorate of HMPPS should amend the guidance on completing the initial segregation health screen to:**

    - **make assessment of a prisoner's physical health as important as assessment of their mental health;**

    - **make it mandatory for the nurse completing the health screen to check the prisoner's clinical record for the health conditions listed in the Use of Force Policy Framework (including sickle cell disease); and**

    - **ensure that physical assessment includes a set of physical observations (blood pressure, temperature, oxygen saturation, pulse and respiratory rate) or assessment using NEWS2.**

- **The Head of Healthcare should ensure that all members of the healthcare team receive supplementary training on their roles and responsibilities with**

regards to physical health checks and paperwork that should be completed when deciding whether a prisoner is fit for admission to the segregation unit.

- **The Head of Healthcare, in conjunction with the Governor, should ensure that healthcare staff can access prisoners' medical records from a device in the segregation unit.**

- **The Prison Group Director for London should write to the Ombudsman setting out how the use of BWVC at Pentonville is being embedded and monitored.**

- **The Governor of HMP Pentonville should introduce a quality assurance process to satisfy himself that the pre-occupancy decency checks are taking place in all residential areas.**

The Investigation Process

22. HMPPS notified us of Mr Bayley's death on 17 May 2022.

23. The original investigator issued notices to staff and prisoners at HMP Pentonville informing them of the investigation and asking anyone with relevant information to contact her. Three prisoners contacted the PPO in response. One left an anonymous voice message, and it was not possible to trace him. One had transferred to another prison. She wrote to him but did not receive a reply. She visited the third prisoner in Pentonville, but he did not wish to say anything.

24. The investigator visited Pentonville on 9 June 2022. She obtained copies of relevant extracts from Mr Bayley's prison and medical records. She visited the wing where Mr Bayley lived, the segregation unit (CSU) and the Inpatient Unit (IPU). She requested CCTV and radio transmissions from the use of force, CSU and emergency response. The prison provided CCTV of the use of force but did not provide CCTV of the CSU or radio transmissions. When we re-requested them later in the investigation, the prison told us that they had not been saved. Our investigation was suspended between 22 June 2022 and 4 July 2023 while the police investigated potential criminal charges.

25. The case was allocated to another investigator on 5 July 2023, after the police confirmed their investigation had concluded as the original investigator had left the PPO. On 13 July, the investigator requested evidence gathered during the police investigation, including CCTV footage from the CSU. The police provided this on 27 November 2023. Further information was obtained from London Ambulance Service and Practice Plus Group.

26. The investigator interviewed five members of healthcare staff at Pentonville during October and November 2023. She interviewed 10 operational staff at HMP Pentonville during February and March 2024 and spoke to four additional staff by telephone and video conference in April and May 2024. She wrote to a member of CSU staff who had been dismissed by Pentonville but received no reply. She contacted the prisoner who had not wished to speak to the original investigator, but he remained unwilling to be interviewed. She also contacted two prisoners identified by the prison as orderlies present in the CSU on 17 May 2022. One declined to be interviewed and one said he had never been a CSU orderly.

27. We informed HM Coroner for Inner North London of the investigation. We have sent the coroner a copy of this report.

28. NHS England commissioned a clinical reviewer to review Mr Bayley's clinical care at the prison. The investigator and clinical reviewer jointly interviewed two members of healthcare staff. We received the final clinical review in June 2024.

29. The Ombudsman's office contacted Mr Bayley's family, via their legal representative, to explain the investigation and to ask if they had any matters they wanted us to consider. The investigator met Mr Bayley's family at their solicitor's office in February 2024 to inform them of the progress of the investigation and to answer questions. We have answered further questions in this report and in separate correspondence.

Background Information

HMP Pentonville

30. HMP Pentonville is a local prison in London that primarily serves the courts of north and east London. Practice Plus Group, in partnership with Barnet, Enfield and Haringey Mental Health Trust, provides healthcare services. The prison has a 22-bed inpatient unit (IPU).

HM Inspectorate of Prisons

31. The most recent full inspection of HMP Pentonville was in July 2022. Inspectors highlighted eight priority concerns, including that the prison was severely overcrowded and could not safely or decently care for the number of prisoners it was required to hold. Inspectors also found that body-worn video cameras (BWVC) were not well enough used and footage was not retained sufficiently long enough to inform learning and improve practice. Use of force had reduced since the previous inspection and managerial oversight was deemed reasonable. Footage showed a lack of de-escalation and staff only used BWVC in approximately half of incidents, which undermined accountability.

32. The segregation unit had improved, and the staff were calm and professional and formed good relationships with prisoners there. Strip-searching was routine for all prisoners who were moved there with no risk assessment to determine necessity.

33. HMIP returned to Pentonville in April 2023 to conduct an independent review of progress. Inspectors reported they were extremely disappointed to find that the prison was even more overcrowded than in 2022 and noted that overcrowding inevitably had a detrimental impact on outcomes for prisoners across several areas.

Independent Monitoring Board

34. 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 31 March 2023, the IMB reported notable success in the disruption of contraband in the prison and a huge reduction in the smell of cannabis throughout the prison. The prison had normalised a regime of only one hour per day out of cell for prisoners. This was partly due to caution after the COVID-19 pandemic and partly due to staff numbers. The IMB were concerned by overcrowding and the expanding population at the prison where physical conditions were neither decent nor humane.

35. The IMB had no significant concerns about use of force in Pentonville. De-escalation was encouraged and members had observed staff attempting to resolve incidents without force. There was evidence of increased but somewhat inconsistent use of BWVC. During the reporting year two or more of the 11 segregation unit cells were usually out of action due to heating or plumbing issues.

Previous deaths at HMP Pentonville

36. Thirteen prisoners died at Pentonville in the three years before Mr Bayley died. Seven of these were self-inflicted, one was drug related and five were from natural causes. In our investigation into the self-inflicted death of a man in 2019 we found that the cell he was moved to the day before he died was not fit to be occupied. In our investigation into a self-inflicted death in 2020 we found that none of the staff that attended the emergency response turned on their BWVC. We discuss our recommendations in these cases and the prison's response to them in more detail in the findings section.

37. Three prisoners have died at Pentonville since Mr Bayley – two of the deaths were self-inflicted and one was the substance misuse related death of a prisoner with epilepsy. None of those investigations were complete at the time of writing in July 2024.

Sickle cell anaemia

38. Sickle cell disease is the name for a group of inherited health conditions that affect the red blood cells. The most serious type is called sickle cell anaemia. Painful episodes called sickle cell crises can be very severe and last for days or weeks. Sometimes sickle cell crisis is triggered by physical stress, such as an infection, and it can also happen without a trigger.

39. Sickle cell crisis can cause a variety of symptoms, including pain, shortness of breath, generalised and severe weakness, low blood pressure and change in consciousness. These symptoms can develop over the course of hours or days.

40. Sickle cell disease is particularly common in people with an African or Caribbean family background.

Segregation units

41. Segregation units are used to keep prisoners apart from other prisoners. This can be because they feel vulnerable or under threat from other prisoners or if they behave in a way that prison staff think would put people in danger or cause problems for the rest of the prison. They also hold prisoners serving punishments of cellular confinement after disciplinary hearings.

42. Prison Service Order 1700 *Segregation* sets out the purpose and reasons for segregation, together with the process that should be followed when a prisoner is segregated. The PSO specifies that an initial segregation health screen must be completed within the first two hours of a prisoner being placed in segregation. This is in the form of an algorithm and is a snapshot assessment of a prisoner's mental well-being to decide whether it is safe to segregate them, although physical health concerns should also be considered.

43. There is no requirement for the nurse to undertake physical observations (such as blood pressure and respiratory rate) and the questions are almost all related to mental fitness for segregation.

44. The guidance instructs the nurse to refer to the prisoner's clinical record and other documentation 'if appropriate'. A prisoner's segregation must then be authorised by a duty governor or operational manager, based on the outcome of the health screen.

- The segregation unit at Pentonville is known as the Care and Separation Unit (CSU).

Key Events

45. On 11 May 2022, Mr Wayne Bayley, a 43 year old black man, was remanded to HMP Pentonville charged with wounding with intent and possession of a bladed weapon in public. Mr Bayley had epilepsy and sickle cell anaemia. His medical records indicated he had been diagnosed with a delusional disorder and was prescribed anti-psychotic medication in 2018. It was not his first time in prison and his previous prison record (NOMIS) should have been merged with the record opened on his arrival but was not.

46. A nurse completed an initial health assessment. Mr Bayley said he had epilepsy and had seizures in his sleep. He said he was on medication but could not remember the name of it. He denied any history of mental health issues or substance misuse.

47. A prison GP also assessed Mr Bayley that evening. She noted that Mr Bayley had sickle cell anaemia and epilepsy but was not currently under the care of a haematologist or neurologist for either condition. Mr Bayley said he had last had a seizure “a long time ago”. She also noted previous prescriptions in 2018 for metformin (a non-insulin treatment for type 2 diabetes) and olanzapine (an anti-psychotic). She prescribed Mr Bayley Epilim Chrono (twice a day) for epilepsy and folic acid (once a day) and penicillin (twice a day) for sickle cell anaemia. She also referred him for a mental health assessment.

48. On 12 May, a pharmacist completed a medicines reconciliation against Mr Bayley’s community GP records. There is no indication on Mr Bayley’s record that his previous prison medical record was merged or linked to his current record as it should have been.

49. On 13 May, a nurse completed Mr Bayley’s mental health in-reach team triage assessment. She reported that Mr Bayley appeared quite anxious but engaged well although he was sometimes difficult to follow and gave a contradictory and confusing life history. He said he heard voices, but they just spoke to him and did not tell him to do anything. He said he had a period in Homerton Hospital in 2011 due to a delusional disorder, which is where he was first prescribed anti-psychotic medication. He said he had stopped taking this four months previously because he was worried he was sleeping too much. Mr Bayley said he did not think he was currently delusional but said he could become paranoid and had recently reported a prisoner staring at him to a landing officer.

50. Mr Bayley’s medication administration history showed that he had all of his prescribed medication from the evening of 12 May until the morning of 16 May. This was the last time Mr Bayley received any medication before he died.

51. On 16 May, Mr Bayley moved from the induction unit on A Wing to cell G4-21 (a single cell on G Wing, a standard prison wing). Mr Bayley’s prison record indicated that his move took place at about 4.00pm in the afternoon (the time of 4.09pm was retrospectively entered on Mr Bayley’s housing history record by the officer in charge of the move). The cell bell record showed the bell was pressed at 4.44pm, 5.32pm and 6.13pm and answered some minutes later in each case. We do not know what Mr Bayley’s concerns were when he pressed his bell that afternoon.

52. Mr Bayley's medication administration record showed that he did not receive his second dose of Epilim Chrono or penicillin that afternoon.

Events of 17 May 2022

53. Mr Bayley's medication administration record showed that he did not attend the G Wing medication hatch to take his medication that morning.

54. Also, during the morning, the mental health in-reach team multi-disciplinary meeting discussed Mr Bayley in the light of the nurse's triage assessment. They noted that Mr Bayley's GP had re-referred him to psychiatric services on 11 February 2022. The meeting agreed to obtain collateral information on Mr Bayley's mental health history and put him on the list for review by the psychiatrist.

Initial use of force

55. The times in this section are taken from the clocks on the different CCTV cameras on G2 landing, the Centre (the section of the prison in-between the different wings), E2 landing and E1 landing (the segregation unit - CSU). Given the length of time between the incident and our investigation we have not tried to determine whether these clocks were synchronised or showed the accurate time. The accounts given by prison staff have been taken from prison and police statements taken in May 2022 and PPO interviews in 2023 and 2024.

56. At 12.18pm, CCTV (which has no audio content) showed Mr Bayley walked towards the gate to the Centre at the end of G2 landing carrying his lunch in a bag. He appeared to gesture to someone, and a Custodial Manager (CM) entered the wing. Mr Bayley had his back to the camera, but, from his body language, appeared to be complaining about something. The CM stood several feet from Mr Bayley and indicated he was listening to him. After about 30 seconds they were joined by Officer A, who stood slightly behind the CM. After listening to Mr Bayley, the CM gestured to Mr Bayley to return to his cell and Mr Bayley appeared to say that he would not and held his lunch up as if in explanation. The conversation continued with the CM apparently repeatedly asking Mr Bayley to return to his cell and Mr Bayley repeatedly replying that he did not want to.

57. The CM said that Mr Bayley was upset about the condition of his cell and said that he would not return there. In his police statement taken on 18 May 2022, he said that Mr Bayley told him that he had told wing staff about this the day before, but no one had taken his concerns seriously. Mr Bayley said he had asked for cleaning materials and had not been provided with them. The CM said he apologised to Mr Bayley and said that should not have happened.

58. Photographs of cell G4-21 taken by the police on the night of 17-18 May 2022, showed that the cell was untidy, with rubbish on the floor and contained another prisoner's possessions including medication, books and a prison identity card.

59. The CM said he tried to persuade Mr Bayley to return to his cell several times and offered to go and see the cell and to provide cleaning equipment for him. When Mr Bayley still said he would not go back to his cell, the CM said he offered to help him

clean the cell. He said this was not something he had offered to do before or since, but he thought it might encourage Mr Bayley to return to his cell. He said he remembered being surprised that Mr Bayley had not accepted this offer. He tried to explore whether Mr Bayley had other issues, but Mr Bayley did not reveal any personal information. He said Mr Bayley did not appear mentally or physically unwell.

60. At 12.21pm, Mr Bayley stepped backwards so that only his shoulders and head were visible on the camera. The conversation apparently continued in the same vein and then the CM appeared to say, “come on” and gestured again toward Mr Bayley’s cell. Mr Bayley shook his head. The CM and Officer A stepped closer to Mr Bayley. The conversation continued with the CM gesturing towards Mr Bayley’s cell and Mr Bayley gesturing that he did not want to go there. At 12.22pm, Mr Bayley put his hand to his head as if distressed or frustrated and stepped back so only his head was visible on camera.

61. Officer B joined them shortly afterwards and the three officers stood around Mr Bayley who was in the corner between the wall and the wing gate. Throughout the conversation Mr Bayley made no aggressive move towards the officers. CCTV showed Officer B was the only one of the three officers wearing a body worn video camera (BWVC). Mr Bayley stepped back under the CCTV camera and out of view.

62. Just before 12.23pm, the CM and Officer B stepped forward and appeared to try to hold Mr Bayley’s arms. Mr Bayley resisted and all three staff, now back on camera, struggled to put Mr Bayley face down on the floor. The officer turned on his BWVC, but the recording cut off after six seconds. In the use of force incident report, the CM stated that use of force was used “To prevent harm, assault or harm to others. Refusal to locate to cell.”

63. The CM was not wearing a BWVC. He said at the time he had not been in the habit of routinely collecting one when he arrived at work. He had also experienced technical difficulties with the cameras in operation at the time.

64. The CM said he had tried to de-escalate the situation, but Mr Bayley seemed determined not to move. He said Mr Bayley was not aggressive, rude or threatening. He did not consider calling for more staff because he thought this would be intimidating for Mr Bayley. He did not think a planned use of force was a safe option given Mr Bayley was on an open landing. (Planned uses of force are supervised by a senior manager in the presence of a nurse and recorded on BWVC and handheld camera.)

65. The CM said he decided to employ ‘guiding holds’ with Officer B to try to encourage Mr Bayley back to his cell. (Guiding holds are the lowest level use of force technique and are generally applied to escort a prisoner away from an area to prevent a situation from escalating.) The CM said Mr Bayley resisted their attempt to use guiding holds so he took a firmer grip of Mr Bayley’s arm and then the officer shouted, “He’s got my baton.” He said this meant that he had to escalate the situation to remove the baton from Mr Bayley. A significant number of other staff responded to the incident and 48 seconds after the alarm was raised there were 18 staff visible on camera. (At least three of those present were wearing BWVCs but none turned them on.)

66. The CM, Officer B, and two other officers managed to put Mr Bayley face down on the floor but struggled to get control of him. Another CM (a use of force instructor) intervened and managed to cuff Mr Bayley's hands behind his back using rigid bar hand cuffs. A Supervising Officer (SO) over Mr Bayley's left arm after the CM applied the hand cuffs. He said Mr Bayley was struggling and "had some power behind him".

67. The CM and SO lifted Mr Bayley to his feet by hooking their arms under his. Officer C took control of Mr Bayley's head. This is a Prison Service control and restraint (C&R) technique known as the underhook position and is used to move a non-compliant prisoner under control. The position causes the prisoner to be bent forward at a 90-degree angle from the waist with an officer controlling each arm and their head. The use of rigid bar hand cuffs meant that the officers did not need to put Mr Bayley in wrist locks and is less painful for the prisoner under restraint.

68. Officer C said Mr Bayley seemed agitated and angry and did not respond when he spoke to him. He said he gave Mr Bayley an opportunity to stand up unaided, but Mr Bayley did not respond, which is why they employed the underhook position. As Mr Bayley remained non-compliant when standing up, the decision was taken to move him to the CSU.

69. Another CM, who was the orderly officer, (known by radio call sign Oscar 1, and the most senior uniformed officer in charge for that shift) attended the incident. When interviewed by the investigator in May 2024, he was now a senior prison manager and said he could not remember the incident or any detail of it. He confirmed that it was usually the orderly officer who took the decision to move a prisoner who had been restrained to the CSU. (He had not previously been asked to make a statement in relation to the use of force incident and had not been interviewed by the police.)

Journey under restraint from G Wing to the Care and Separation Unit (CSU)

70. CCTV footage showed Mr Bayley walked bent forward from the waist across the area called the Centre, with the same officers controlling his head and arms. The orderly officer walked in front of the party, a CM walked behind the party and the designated emergency response nurse, known by radio call sign Hotel 7, followed behind them. The nurse carrying Hotel 7 is required to attend all unplanned use of force incidents to monitor the health of the prisoner. There were still a significant number of other staff present.

71. CCTV showed Mr Bayley and the officers entered the sterile area at the top of E2 landing (the CSU is downstairs on E1 landing). Part way across E2 sterile area, Mr Bayley's legs appeared to give way and he dropped to his knees. He was dragged for a couple of paces on his knees and then the group stopped for about 20 seconds. The orderly officer had his back to the group as Mr Bayley fell to his knees, the CM was putting his bag in the sterile area office and the nurse was still in the Centre talking to another nurse and did not watch the group enter the E2 sterile area.

72. Officer C said he believed Mr Bayley had deliberately dropped to his knees because when he asked him to get up, Mr Bayley said "I'm not fucking moving - get off me". The officer said he thought the only way of distinguishing between someone who

was ill and someone who was non-compliant was to test their compliance by giving them instructions. The nature of Mr Bayley's response reinforced his opinion that Mr Bayley was being non-compliant. The officer said he asked Mr Bayley several times to stand up and he did not comply. He therefore told Mr Bayley that the officers would lift him and carry him to the CSU.

73. A SO and an officer helped staff lift Mr Bayley by each holding one of his legs. At this point the nurse entered the E2 sterile area. The officers carried Mr Bayley face down through the gate at the other end of the sterile area to the top of the stairs down to the CSU. A CM told us that he saw staff carrying Mr Bayley as he exited the staff office having deposited his bag. He said he shouted to the group (because this was not an approved technique in C&R), and they lowered Mr Bayley to his knees. The officers then lifted Mr Bayley into a sitting position.

74. Officer C said, after he was first picked up, Mr Bayley told him he could not breathe. He instructed the officers to put Mr Bayley down and they pulled his shoulders back to open his diaphragm. A SO said Mr Bayley was in distress and was having difficulty breathing but appeared to recover once they had stopped. Officer C said once Mr Bayley had recovered his breath, he asked him if he would stand up. He said Mr Bayley said more than once, "I ain't moving nowhere". The officer said a CM and the orderly officer gave permission for them to continue to move Mr Bayley under restraint to the CSU.

75. The nurse joined the group when Mr Bayley was still on his knees. She watched from a few feet away. She did not intercede or appear to say anything but did move to get a better view. The officers picked Mr Bayley up using a C&R technique called a cuff carry and carried him down the stairs to the CSU. The Duty Governor and the nurse followed the group down the stairs.

Search in CSU and location in cell E1-16

76. The officers placed Mr Bayley in a seated position on the floor at the bottom of the stairs. He was bent forward with his head almost on his knees and his hands still hand cuffed behind his back. CSU staff took over from the officers that had brought him from G Wing and staff picked Mr Bayley up and cuff carried him to the room used for searches, followed by a CM and the orderly officer. There is no CCTV in the search room.

77. Officer D said he took the responsibility of lead officer for the process of searching Mr Bayley and putting him in a cell. He said he asked Mr Bayley if he would stand and walk to the search room and Mr Bayley told him to "fuck off". He said Mr Bayley appeared angry and aggressive but physically well. He said they carried him into the search area where Mr Bayley continued not to comply with any of his instructions. In his use of force statement, he said he guided Mr Bayley's head to the floor with two SOs still in control of each of his arms. As Mr Bayley was non-compliant, the officer said it was deemed safer for all concerned if Mr Bayley's clothes were removed from him.

78. A CM said he remained present for the search because he wanted to retrieve his hand cuffs. He removed the hand cuffs while Mr Bayley was on the floor in the search area. He said the CSU staff tried to encourage Mr Bayley to stand up, but he refused. As he was about to leave the staff asked him to assist with the search. He

said Mr Bayley laid on the floor on his front and side as if he was almost in the recovery position. He said Mr Bayley would not comply with any of Officer D's instructions, so they decided to search him while he was lying on the floor. He said Mr Bayley was not under restraint during the search.

79. The CM said he removed Mr Bayley's shoes, socks and tracksuit bottoms. He said he could not remove Mr Bayley's boxer shorts due to the position he was lying in. He was concerned at how long the restraint had taken so he decided to cut Mr Bayley's boxer shorts and vest off. He placed an article of prison clothing over Mr Bayley's lower half while he did this. He said when he cut his vest off, Mr Bayley became angry and told him that it was a gift from a family member, and he would wait outside for him and kill him.

80. In his statement, a SO said at the end of the search Mr Bayley was still non-compliant, so Officer D asked for hand cuffs to be re-applied. CCTV showed Mr Bayley was in the search room for five minutes between 12.31pm and 12.36pm. Two SOs and Officer D carried him out of the search room naked and covered in a blanket, followed by a CM carrying a clean set of prison clothes. They carried Mr Bayley into cell number 16. The clean clothes were left in the cell with Mr Bayley, but he did not put them on.

81. At 12.38pm, the nurse entered Mr Bayley's cell for 29 seconds. As she left, she spoke to the Duty Governor and the orderly officer before they all left the landing at 12.39pm.

82. The nurse said she arrived when Mr Bayley was on the floor being restrained by officers. She did not remember seeing Mr Bayley drop to his knees in E2 sterile area, but she remembered him being carried down to the CSU. She said she asked the officers why he was being carried and they told her that he was non-compliant. She said she was not allowed into the search area but saw Mr Bayley in his cell. She thought it was odd that he was not dressed but did not ask anyone why this was the case.

83. The nurse said Mr Bayley did not respond to any of her questions when she tried to complete the initial segregation health screen in his cell. She said her role was to check for injuries and assess whether Mr Bayley was mentally fit for segregation. When Mr Bayley did not answer any of her questions, she became more concerned for his mental state. She said she was unable to assess Mr Bayley's mental fitness for segregation, so she asked the officers to contact the mental health team and ask a nurse to come and assess him.

84. The nurse said she did not look at Mr Bayley's clinical record because she was unable to access it in the CSU. She said nurses had been able to do this previously, but she was not sure whether the terminal was broken or had been removed. She also did not complete the initial segregation health screen to say whether or not she considered him fit to be segregated. She completed a 'report of injury to an inmate' form, which was a standard procedure following the use of control and restraint. She noted that Mr Bayley had no physical injuries and was breathing normally.

85. A SO said Mr Bayley did not respond to any of the nurse's questions. He remembered that she did not complete the initial segregation health screen and

thought she had said she would come back later during the two-hour window to do it.

86. The Duty Governor said that her understanding was that Mr Bayley was deemed non-compliant and therefore unsuitable to return to his wing. She understood that the nurse had not completed the initial segregation health screen and would return to see Mr Bayley within the two-hour window allowed for completion.

87. We were not provided with a copy of the initial segregation health screen in the original evidence and the prison was subsequently unable to find it. The HMPPS Early Learning Review completed in May 2022 referred to seeing the document and that it was blank. We understand that this document was subsequently disclosed to all parties as part of the pre-inquest review process.

88. CCTV showed no one went to Mr Bayley's cell during the lunchtime patrol period.

CSU 2.00pm – 4.15pm

89. At interview, a number of CSU staff said they remembered 17 May as especially busy with electrical and plumbing faults on the unit. There is evidence to support this on CCTV with several workmen present throughout the afternoon.

90. At 2.00pm, a CSU SO looked through Mr Bayley's observation panel for a few seconds. Four minutes later he returned to the cell with Officer E. They stayed at Mr Bayley's door for a few minutes before the officer opened the cell. The officer stayed in the doorway of Mr Bayley's cell for some 12 minutes in total. A CSU CM and another officer also looked through Mr Bayley's observation panel apparently at the behest of Officer E. Officer E and the CSU SO looked through Mr Bayley's observation panel again at 2.32pm and 2.38pm respectively (more frequently than they were required under CSU policy).

91. The CSU SO said when he checked Mr Bayley immediately after lunch, he was naked and had defecated in the cell. He was sitting on the floor between the bed and the window. He went to tell his colleagues to open a dirty protest log and then returned to the cell with Officer E. The CSU SO said Mr Bayley was shouting and complaining about his wrists. We were not provided with a dirty protest log (which should be opened if a prisoner is considered to be purposefully defecating not in the toilet) in the original evidence and we were told that the prison was unable to find it. We understand that it was subsequently located and provided to all parties during the pre-inquest review process.

92. The police provided us with crime scene photographs taken of Mr Bayley's cell on the CSU. There was faeces on the floor quite close to the toilet but also around the toilet seat.

93. Officer E said it was his practice to try to break down any barriers with new prisoners by opening their doors and speaking to them. When he opened Mr Bayley's door, he noticed faeces on the floor and around the sink and the toilet. Mr Bayley was sitting on the floor between the back wall and the bed looking straight ahead at the opposite wall. He said Mr Bayley did not acknowledge him at first but turned to look at him after he introduced himself. At this point he said he noticed that Mr Bayley appeared to be naked. Mr Bayley told him that his wrists hurt.

94. Officer E said he knew the nurse had not completed the initial segregation health screen, so he kept an eye out for her to let her know she needed to see Mr Bayley. In his police statement he said, at some point, Mr Bayley told him that he had sickle cell and he responded that he would let the medical staff know. At interview, the officer said he was unable to remember Mr Bayley saying this and did not know anything about sickle cell disease.

95. At 2.42pm, staff went to Mr Bayley's cell, with a senior prison manager, carrying out prison disciplinary hearings in the CSU. Officer E opened the cell door and stood in the doorway apparently talking to Mr Bayley for about three minutes before they all moved away. (At various points during the afternoon, different members of staff opened Mr Bayley's cell door. However, at interview, no one could remember exactly what, if anything, was said during specific exchanges.)

96. The CSU SO said he spoke to the senior prison manager about Mr Bayley and the manager said he would have to stay in the CSU if he was on a dirty protest, but a nurse would still need to complete the segregation health screen (which had not happened yet). The senior prison manager told the investigator that he was unable to remember any detail of that day.

97. At 2.49pm, a prisoner orderly looked through Mr Bayley's observation panel and gestured to the CSU SO. He too looked briefly through the panel. The prison identified the two prisoner orderlies working on the segregation unit that day and the investigator contacted them via the safer custody teams at their new prisons but neither wished to be part of the investigation. Staff all looked through Mr Bayley's observation panel at different times between 3.12pm and 4.14pm.

98. The CSU SO said he tried to contact the nurse three times to ask her to come down and complete the initial segregation health screen. Twice she was with patients. On the third occasion she told him that she was not going to sign the initial segregation health screen and that if Mr Bayley was to remain in segregation a mental health nurse would have to sign to say he was fit to remain there. The SystmOne (medical record) login audit for 17 May, showed the nurse accessed Mr Bayley's clinical record for the first time at 3.52pm, and we consider it probable that this was during the conversation with the CSU SO. The CSU SO said he rang the mental health team immediately after speaking to the nurse. He did not remember if he had to call them more than once.

99. The CSU CM said that the nurse had refused to complete the health screen that day. He said that that he considered it the responsibility of the CSU SO to chase the nurse to complete the health screen. He said that if the nurse did not complete the initial segregation health screen within the two-hour window, then the CSU SO should escalate the issue to the duty governor for them to chase the nurse. If a prisoner is not assessed as fit for CSU after two hours they should be returned to their wing or moved to the inpatient unit. He said he did not remember having any conversations with the senior prison manager or the Deputy Governor on 17 May. He said the only other course of action would have been to escalate the matter to the healthcare managers, but he did not think that this had been done.

CSU 4.15pm – 7.25pm

100. At 4.15pm, staff opened Mr Bayley's cell and passed a blanket into the cell. They stayed at the door open for about five minutes. Officer E closed the door at 4.20pm. At 4.23pm, the duty mental health nurse arrived on the CSU and looked through Mr Bayley's observation panel. As she walked away to leave the CSU less than a minute later, she spoke to the Deputy Governor.

101. The duty mental health nurse said at about 4.00pm, the CSU SO rang the mental health team and spoke to her, then her manager, to request a mental health nurse assess Mr Bayley. She said she was the duty mental health nurse and, as it was an urgent request, she went to the CSU almost immediately, having only had time to read Mr Bayley's prescribed medications on his medical record. The SystmOne login audit for 17 May, showed she accessed Mr Bayley's clinical record at 4.01pm.

102. The duty mental health nurse said the CSU SO told her that they would not open Mr Bayley's cell door because of his earlier behaviour (we have not been able to establish from CCTV whether she asked for the door to be opened), so she observed him through the observation panel. Mr Bayley was lying on the bed, naked, with his eyes closed and facing the wall. She saw faeces on the toilet seat and on the floor. She said she asked Mr Bayley to come to the door so she could speak to him, but he did not respond and started muttering as if he was responding to auditory hallucinations. She asked him several times to come to the door, but he continued muttering with his eyes closed.

103. The duty mental health nurse said she could not hear what Mr Bayley was saying. She asked him why there was faeces in his cell, but he did not respond. She said a mental health assessment did not involve completing physical observations and she assumed that the emergency response nurse, as a general nurse, had completed these earlier. She concluded that Mr Bayley was experiencing a mental health crisis, was not fit to remain in the CSU and needed to be transferred to the inpatient unit (IPU). She told staff of her decision and said she would return immediately to healthcare and speak to the psychiatrist and the ward manager and get their agreement to the transfer. She said she was not presented with an initial segregation health screen to complete, and her focus was on returning to healthcare to get the necessary clinical agreement for Mr Bayley to transfer to the IPU.

104. After the duty mental health nurse left, the Duty Governor looked briefly through Mr Bayley's observation panel. The CSU CM then opened the door and stood talking at the door until 4.26pm. The CSU CM said Mr Bayley was lying on the bed on his front and was naked. He said there was faeces on the floor, but he did not think Mr Bayley was engaging in a dirty protest as there was no faeces smeared on the walls. He said the fact that Mr Bayley had gone to the toilet on the floor and was naked led him to believe that he was not mentally well. He said Mr Bayley told him to "fuck off" and that he did not need any help.

105. The duty mental health nurse said she spoke to two psychiatrists and the IPU manager, and they agreed Mr Bayley should move there. The duty mental health nurse recorded her assessment and the plan to move Mr Bayley to the IPU on SystmOne at 4.22pm. She did not complete the standard IPU referral form.

106. The IPU manager then confirmed their agreement with the Duty Governor and asked her to move a prisoner to make space for Mr Bayley as the IPU was full. The Duty Governor said she remembered that a prisoner had to move from the IPU to a standard wing, and another prisoner needed to move cells in the IPU before Mr Bayley could move from the CSU.

107. At 4.29pm, staff and an orderly served the tea meal to the prisoners on the CSU. They walked past Mr Bayley's cell without stopping (at this point, Mr Bayley had not eaten or drunk anything since arriving in the CSU). At interview, no one could remember why Mr Bayley was not given a meal. Mr Bayley's CSU record showed erroneously that he was given a meal at 4.30pm.

108. At 4.45pm, the same prison orderly as before gestured to Mr Bayley's door and an officer opened the door and passed Mr Bayley some toilet roll. Half an hour later, the CSU SO opened Mr Bayley's door and gave him a set of clean prison clothes and a pair of shoes. The CSU SO said Mr Bayley was sitting up on the edge of the bed. He told Mr Bayley that he needed to clean the cell and get dressed because he would be moving to the IPU.

109. At 5.41pm, an officer answered Mr Bayley's cell bell. He spent about 30 seconds at Mr Bayley's door. The officer no longer works at Pentonville. The investigator wrote and asked to speak to him for the investigation but received no reply.

110. The CSU SO said he called the IPU several times from about 5.00pm to ask if Mr Bayley's cell was ready. Eventually he was told the move would take place in the Evening Duty (ED). He said he went to the IPU and helped an officer (the healthcare officer on duty) to move a prisoner between cells and clean the cell Mr Bayley was due to move to.

Journey from the CSU to the IPU

111. At 7.25pm, staff gathered outside Mr Bayley's cell. At 7.31pm, Mr Bayley left his cell and walked towards the CSU stairs supported by the CSU SO and the healthcare officer. CCTV shows that his head was bowed, he looked unsteady and unable to support his own weight. It appeared to take some effort for him to walk up the stairs. Mr Bayley walked very slowly along E2 landing supported by the two officers. As they left the landing by the side gate at 7.34pm (by the E2 CCTV camera clock), Mr Bayley dropped to his knees. This is the last time he was seen on CCTV. The investigator asked for CCTV of the E2 yard but was told none had been gathered at the time of the incident.

112. The CSU SO said when he opened Mr Bayley's door he was lying on his bed and dressed but with his trousers down by his ankles. He pulled them up, washed his hands, walked towards the door but then sat back on the bed and said he did not have the strength to move. The Duty Governor said they put a chair outside the cell and encouraged Mr Bayley to come out. He continued to say that he was not able to move so she told him not to worry and that the officers would help him.

113. Officer D was also present. He said Mr Bayley was a "different gentleman" to the one he had met on his arrival in the CSU. He said Mr Bayley appeared to have aged about 20 years and his manner was completely different. Mr Bayley responded when spoken to but did not say very much. He said Mr Bayley's legs

gave way after they walked through the E2 side gate, and they decided to get the evacuation chair from the Centre and take him the rest of the way in that.

114. A SO who was also present said he tried to turn on his BWVC before the CSU SO opened Mr Bayley's door, but it was not working. He said the BWVC system was temperamental and the cameras either did not work or shut off after five or ten seconds. (They had since been replaced with a new system and he had not experienced any problems with that.) He said Mr Bayley appeared physically weak. He was concerned about his wellbeing but reassured by the fact that he was being taken to the IPU where he would receive medical help and be observed regularly.

Initial period on the IPU before handover to night staff

115. There is no CCTV on the IPU at Pentonville. We do not know exactly what time Mr Bayley arrived there or the exact time the following events took place. Based on the time on the E Wing CCTV clock and the healthcare observation book we estimate Mr Bayley arrived in the IPU shortly before 7.40pm. The information in this section has been taken from prison records, police and PPO interviews.

116. The healthcare officer said that said that healthcare staff would normally be waiting to take the prisoner's physical observations when they arrived on the IPU, but he did not remember seeing anyone there. He said he was concerned to get Mr Bayley into a cell before 8.00pm because that was when he was required to complete a routine count of the IPU prisoners (known as the evening roll check, when officers on each unit check and count their prisoners). He also had to record the different cell moves for Mr Bayley, the prisoner who had moved from the IPU and the prisoner who had moved cells on the IPU on NOMIS.

117. The healthcare officer said he gave Mr Bayley a new set of clothes and bedding. He asked him if he wanted any water or a breakfast pack, and Mr Bayley said he did not and that he was fine.

118. A healthcare assistant on duty said Mr Bayley arrived in an evacuation chair accompanied by several officers. She went to find the IPU nurse on duty, but she was either in the toilet or the staff room. She returned to the landing as the officers were leaving. She could not remember if any of them spoke to her, but she remembered at some point she was told that Mr Bayley had been aggressive earlier in the day.

119. She introduced herself to Mr Bayley. He was lying on his bed and told her that he could not breathe. She said she asked him several questions to gauge how he was, including asking him if he was asthmatic. She said Mr Bayley appeared annoyed by the questions and she remembered him saying, "No, I'm just tired." She said she did not see any physical evidence that Mr Bayley was struggling to breathe.

120. The healthcare assistant said the IPU nurse joined them and also tried to talk to Mr Bayley, but he either ignored the questions or repeated that he was tired. At one point she said Mr Bayley became angry and told them that he had been restrained several times. She began an IPU observation record (all new admissions to the IPU are observed every 15 minutes for the first 24 hours). This has pre-printed times on the hour and at 15, 30 and 45 minutes for each hour. The IPU observation record

showed that she recorded her first check at 7.30pm. We think this indicates that the first check was before 7.45pm.

121. The IPU nurse said that at about 4.30pm she was made aware that Mr Bayley would be transferring to the IPU. She remembered being told that there were concerns about his mental health, he had been behaving very oddly, had smeared faeces over himself and that he had been restrained. She did not know what time Mr Bayley was due to arrive and she did not hear the move announced on the radio. She said an officer did not tell her he was going to collect Mr Bayley. She was in the toilet when Mr Bayley arrived and, by the time she returned to the landing, Mr Bayley was locked in his cell and the escorting officers had left.

122. It is IPU policy that all new admissions should have their physical observations taken. The IPU nurse said, normally, when she is aware that a prisoner is coming to the IPU, she will be waiting for him with a trolley in order to do complete them, however this had not happened in Mr Bayley's case. As it was ED (when staffing levels are reduced and procedures for opening cells more complex) she said she would have had to ask the orderly officer to come and open Mr Bayley's cell. She did not do this. She had not had time to look at Mr Bayley's clinical record, as she had been the only nurse on duty since 7.30am that morning (there should be two nurses on duty during the day and cover for the lunch period but no one else had been available). Neither had she completed any part of Mr Bayley's initial admission paperwork comprising the admission assessment form and initial risk assessment. (The former is where initial observations are recorded.)

123. The IPU nurse said it was getting close to the end of her shift, so she went to see how Mr Bayley was before she left. She said before she arrived Mr Bayley had pressed his cell bell, so she cancelled the buzzer and introduced herself. Mr Bayley asked to see a doctor. She asked him why he needed to see one and he reiterated that he just wanted to see a doctor. She told him that she needed to know why he wanted a doctor. As Mr Bayley was about to reply, a prisoner on the opposite side of the landing began banging loudly on his door. She said she could not hear what Mr Bayley said and he became irritable, waved his hand at her and stopped responding to her questions.

124. The IPU nurse said there was a doctor in reception at this point. She did not call the doctor over but told Mr Bayley that the night staff would deal with his request.

125. The healthcare assistant said when she checked Mr Bayley for the second time, he had moved from the bed to the floor and was lying on his back with his legs up on the bed. She asked him if he was OK, and he nodded. The IPU observation record showed she checked Mr Bayley for the 7.45pm and 8.00pm checks. On both occasions she recorded that he was "lying on floor, awake".

Handover to night staff and night observations

126. The night nurse said she came on duty at 8.00pm with the night HCA. The night nurse said she received a handover from the ED staff in the IPU main office. She remembered being told that Mr Bayley was a new admission who had just been transferred in at about 7.40pm using an evacuation chair. She said the IPU nurse had not had a chance to have a proper conversation with him, but she remembered being told that Mr Bayley had epilepsy and sickle cell anaemia. She also

remembered that Mr Bayley had been in the CSU after being restrained, he was non-compliant and had his clothes removed by staff during a search, had been behaving oddly, had been naked in his cell and had defecated. She was also told that Mr Bayley's physical observations had not been done.

127. The night nurse said she asked why the officer had not opened the cell to allow the IPU nurse to take Mr Bayley's observations and the IPU nurse had said that they were not happy to open the cell because Mr Bayley had been aggressive earlier. At interview the healthcare officer said no one had asked him to open Mr Bayley's door. The night nurse did not ask anyone to come and open Mr Bayley's door.

128. The IPU nurse said she explained to the night nurse that Mr Bayley had asked to see a doctor and that she had not heard his explanation of why. She told the night nurse that, "I haven't done anything for him at all" and asked her to complete the paperwork and follow up Mr Bayley's request for a doctor. She said she went off duty at about 8.30pm.

129. The night nurse said she only became aware that Mr Bayley had asked to see a doctor when she read his clinical notes after she had completed the night medication round at about 10.00pm. In any case, she did not contact the doctor in reception.

130. The night nurse said she introduced herself to Mr Bayley after handover. He was laying on his back on the floor with his feet on the bed. She said she asked Mr Bayley why he was laying on the cold floor and suggested he get into bed and sleep there. She said had his eyes open and looked at her but ignored her question and turned the other way. She decided to leave him for 15 minutes while she checked the other prisoners.

131. When she went back Mr Bayley was sitting up with his back resting on the cell cabinet. She again suggested he get into bed and Mr Bayley just shook his head. She said in her experience prisoners that have been restrained are normally exhausted, so Mr Bayley's presentation did not alarm her. She did not know when Mr Bayley had been restrained. She said Mr Bayley's presentation was consistent with the information handed over to her that he was non-compliant and not really engaging with staff.

132. The IPU observation record showed the night nurse checked Mr Bayley around 8.15pm, 8.30pm and 8.45pm. At 8.15pm she wrote, "Sitting up on the floor. Appears to be sleeping." At 8.30pm and 8.45pm she wrote that he was seated on the floor, sleeping. She also said Mr Bayley was asleep at all three of her checks in her police statement, made in May 2024.

133. The night patrol officer support grade (OSG) came on duty at 9.00pm. He took over responsibility for checking Mr Bayley while the night nurse completed the evening medication round. He said that either the healthcare officer or the night nurse told him that Mr Bayley was a new arrival and had been restrained during the day. Mr Bayley's medical record indicated that he was not given his evening medication.

134. The OSG said the first time he checked Mr Bayley, at about 9.00pm, he was sitting up with his back to the cell cabinet asleep. He said he could see Mr Bayley breathing lightly, his head was slightly forward as if he had fallen asleep. His knees

were slightly bent, and his hands were at his side near the pockets of his trousers. He said the main light was on in Mr Bayley's cell. He said it was not unusual to see prisoners asleep on the floor rather than in bed.

135. The IPU observation record showed the OSG checked Mr Bayley at 9.15pm, 9.30pm, 9.45pm, 10.00pm and 10.15pm. He said that checks should not be at exactly every 15 minutes, but the record is pre-printed with the 15 minute observations. He said that Mr Bayley's arms moved position slightly during the first hour. His entries on the IPU observation record simply stated that Mr Bayley was "asleep" at every check.

Emergency response

136. As noted above, there is no CCTV on the IPU. No staff activated their BWVC, and we were not provided with radio traffic from the incident, although we have seen the radio log which recorded significant events. The information in this section has been taken from prison documents, police statements, PPO interviews and London Ambulance Service (LAS) records.

137. At the 10.30pm check, the OSG said he became concerned that he could not see Mr Bayley breathing. (He remembered this as the 10.15pm check but all the other evidence indicated that it was the 10.30pm check.) He said he watched him for about a minute and then banged on the cell door and called out, "wake up my friend". Mr Bayley did not respond, so he opened the larger medication hatch in the door and shouted to Mr Bayley and banged the inside of the cell door. Mr Bayley still made no response, so he went to the night nurse and told her that he was worried about Mr Bayley.

138. The OSG returned to the cell and continued to shout and bang the door. He said the night nurse joined him immediately. He then threw a breakfast pack containing tea bags and sugar at Mr Bayley hitting him on the arm, but Mr Bayley still did not respond. (In interview, he expressed regret at having done this, but said that he just wanted Mr Bayley to respond.) He said he told the night nurse that they should radio an emergency. He tried to use his radio, but the control room was unable to hear him, so the night nurse used hers instead. He said in cases where there is a risk to life night staff are allowed to break open their sealed pouches and use the cell key inside to enter the cell without the orderly officers being present. In this case he decided not to do this because he did not know Mr Bayley and he only knew that he had been restrained earlier in the day.

139. The night nurse said she could not see Mr Bayley breathing either. She called his name a couple of times and then decided to radio for help. She said she called a code blue (which indicates a prisoner is unconscious or not breathing and alerts staff in the control room to call an ambulance), asked for healthcare staff to attend and went to collect the emergency bag and an oxygen cylinder in readiness. She too decided it was appropriate to wait for other staff to arrive before entering Mr Bayley's cell because Mr Bayley had needed several staff to restrain him earlier in the day. She said the night orderly officer (a CM) and the two other assistant night orderly officers arrived after a few minutes.

140. The night orderly officer said he heard a radio call for him to attend the IPU at about 10.40pm. He said he arrived to see the OSG standing outside Mr Bayley's cell. He

looked through the observation panel, saw Mr Bayley was unresponsive and opened the door. He said he grabbed Mr Bayley's shoulder, but he did not respond so he radioed for an ambulance. The prison radio log recorded that he radioed a code blue emergency at 10.44pm. LAS records showed the control room officer called 999 at 10.45pm, presumably in response to the night orderly officer's code blue and not the night nurse's code blue a few minutes earlier.

141. The night nurse said she asked the orderly officers to lay Mr Bayley in the middle of the cell. She checked for signs of breathing but did not find any. Mr Bayley was easy to move but she noticed some stiffness in his hands and his palms were very cold. When she tried to put an airway in, she was unable to open Mr Bayley's mouth because his jaw was too stiff. As Mr Bayley's mouth was slightly open, she decided to put the ambu bag mask over Mr Bayley's mouth and administer oxygen anyway. She started chest compressions. She said the night HCA helped, and when she squeezed the ambu bag there was a slight chest rise indicating some oxygen was getting into Mr Bayley.

142. The emergency response night nurse said in his police interview that he heard the nurse radio a code blue emergency, ask for an ambulance and for him to attend the IPU at about 10.40pm. He responded immediately and said he was about 20 metres behind the CM. He helped administer chest compressions until the ambulance paramedics arrived.

143. LAS documents and the 999 call recordings showed that the control room officer communicated the nature of the emergency effectively and an ambulance was dispatched with the highest priority at 10.46pm. The control room officer told the call handler to direct the ambulance to the main prison gate. The control room officer called 999 again at 10.51pm to redirect the ambulance to the other prison gate at the rear of the prison. The call showed that the ambulance had already arrived at the main gate at this point and the control room officer redirected the driver via the intercom. LAS records showed paramedics were with Mr Bayley at 11.00pm.

144. Paramedics were also unable to insert an airway because Mr Bayley's jaw was too stiff, so they inserted a nasopharyngeal airway instead (a breathing tube that goes through the nose to the back of the throat). They examined Mr Bayley for signs unequivocally associated with death and noted that rigor mortis was not pronounced although Mr Bayley had some stiffness in his arms and fingers. They continued chest compressions and oxygen therapy but pronounced Mr Bayley dead at 11.46pm.

Contact with Mr Bayley's family

145. The prison appointed two family liaison officers (FLO). They intended to visit Mr Bayley's mother at her home, but he had not provided her address, so they telephoned her instead and arranged to visit the following day.

146. One FLO told the investigator that she spent some time with Mr Bayley's mother and a number of other family members. She agreed to return the following day to pray with the family. However, the police investigator instructed the prison that they were to have no further contact with Mr Bayley's family. The FLO said she found this disappointing and distressing, especially as she had promised to see the family

again. Mr Bayley's mother told the investigator that she had also found the police decision not to allow contact further contact with the FLO distressing.

147. The prison made a financial contribution to Mr Bayley's funeral in line with national guidance.

Support for prisoners and staff

148. After Mr Bayley's death, the Duty Governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

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

Report on the use of force

150. In June 2022, the then Head of Safer Custody, commissioned a member of the National Incident Management Unit (NIMU) of HMPPS to undertake a review of the use of force on Mr Bayley. He asked the member to report on whether the use of force was necessary, reasonable and proportionate to the circumstances and whether the correct control and restraint techniques were used throughout. The member was given access to CCTV and the incident reports from the staff involved. He did not undertake interviews.

151. The member found that:

- There was no evidence from the footage to support use of force being used "to prevent harm, assault or harm to others" or that Mr Bayley was actively moving towards the officers.
- There was no evidence that staff were at immediate risk of harm and there was sufficient time and resources to summon the orderly officer and duty governor and manage the situation in a more structured way by planned removal.
- The use of guiding holds was not advisable in this situation because Mr Bayley was not compliant with a CM's instructions to move back towards his cell.
- Despite these conclusions, the CM's actions were justified and within policy in that he tried to persuade Mr Bayley to comply with a lawful order and first attempted low-level techniques.
- Mr Bayley did not attempt to strike staff, but he did continually resist their attempts to control him. The failure of guiding holds and resistance from Mr Bayley gave staff no option but to apply a three-officer team restraint.
- Staff applied the correct techniques and followed medical guidance by not applying pressure to the neck or torso once Mr Bayley was on the floor. The

force used to take him to the floor was necessary, reasonable and proportionate.

- The rigid bar hand cuffs were applied appropriately. The underhook position was correctly applied to move Mr Bayley.
- Mr Bayley lacked energy and was struggling physically when he dropped to his knees in E2 sterile area, and a member of healthcare should have assessed him at this point.
- Mr Bayley was picked up using an incorrect carry technique in E2 sterile area.
- The correct carry technique was applied to carry Mr Bayley down the stairs to the CSU.
- The description of the search under restraint in the CSU was consistent with taught techniques and the reapplication of hand cuffs allowed a more rapid escort to the cell and limited any application of physical restraint holds.
- There was no incident debrief as there should have been.
- The move from the CSU to the IPU was handled professionally and with compassion. The use of the evacuation chair showed good judgement. As the incident was a planned removal a member of healthcare should have been present.

152. The member made a number of recommendations to the prison including extra training in certain techniques and instructions to staff to turn on their BWVC.

Post-mortem report

153. The pathologist gave the cause of Mr Bayley's death as 'unascertained'. He said he could not find conclusive proof that Mr Bayley had suffered an epileptic seizure or a sickle cell crisis, although he acknowledged he was an expert in neither. The post-mortem report showed that Mr Bayley had COVID-19 when he died. Toxicology showed that Mr Bayley had used cannabis at some point before he died. Epilepsy medication was also present at therapeutic levels.

Inquest

154. The Coroner's inquest held 17 October to 1 November 2024 gave the medical cause of death as:

1a acute chest syndrome

1b hypoxia and chronic sickle cell lung disease

1c sickle cell disease and restraint

155. The jury returned a narrative verdict which identified the following causative failures:

1. The interpretation of non-engagement as non-compliance.
2. A lack of accurate communication between prison officers and healthcare staff.
3. Failure to monitor closely enough Wayne's physical condition or recognise any deterioration.
4. Failure to undertake physical observations.
5. Failure to immediately consult the medical records.
6. Failure to adhere to medical protocol, instead placing mental health over physical health.
7. Death was contributed to by neglect.

Findings

Use of force 17 May

Incident on G Wing

156. Prison Service Order (PSO) 1600 '*Use of Force'* was the guidance in operation in May 2022. This was replaced by the Use of Force policy framework on 31 December 2023. PSO 1600 advised that a use of force would only be justified, and therefore lawful, if it was reasonable in the circumstances, necessary, if no more force than necessary was used and if it was proportionate to the seriousness of the circumstances. Examples of circumstances when force might be necessary included risks to life, limb, property and the good order of the establishment.

157. Paragraph 2.5 stated that a prisoner refusing to comply with any lawful order was insufficient reason to justify a use of force. Paragraph 2.7 acknowledged that deciding whether force was necessary to maintain the good order of the establishment was complicated and gave three examples to illustrate this. The example most analogous to the incident involving Mr Bayley is example 2, in which a lawful order is given to a prisoner to stop swearing at a teacher. The guidance advised that force would not be necessary in that case however "subsequent refusals to leave the classroom/stop swearing at the teacher may eventually lead to a C&R planned intervention".

158. The PSO further stated that planned interventions should be used when there was no urgency or immediate danger. A supervisor would then be able to prepare staff for the incident and notify a member of healthcare in advance who would attend and observe the intervention. Unplanned incidents should be reserved for situations in which there was an immediate threat to someone's life or to the security of an establishment and staff needed to intervene straight away.

159. The Use of Force training manual in operation at the time described a guiding hold as the lowest level use of force technique that can be applied by one or two officers to enable them to escort a prisoner through or away from an area in order to prevent a situation from escalating. Guiding holds should only be used in direct response to any warning signs that a risk to others or the officers is considered possible. To apply a guiding hold correctly staff should approach from the rear or side of the prisoner's arm.

160. Annex C of PSO 1600 offered further guidance to de-escalating situations. One was to "allow greater body space than normal".

161. The Use of Force Policy Framework reaffirms that using force to restrain a prisoner should always be viewed as the last available option. The application of physical techniques is only to be used when other methods not involving the use of force have been repeatedly tried and failed. Passively protesting prisoners who might present as agitated and angry and refuse to engage, should be dealt with by a Level 1 planned use of force (a ratio of three staff to one prisoner, a supervisor, a healthcare professional, BWVC and a handheld camera).

162. We have also considered whether the use of force was appropriate and justified and have reached different conclusions to the member of NIMU. We acknowledge that we are considering the events of 17 May 2022 with the benefit of hindsight and without the benefit of BWVC and audio of the incident (discussed in a separate section below). However, we consider that it is clear from both the former and current guidance and the available evidence that the initial use of force (i.e. when a CM decided to use guided holds) was not justified because:

- There was no evidence to support the recorded reason for the use of force i.e. *to prevent harm, assault or harm to others*.
- The CM has said consistently that he did not feel threatened by Mr Bayley and Mr Bayley was not aggressive, rude or threatening to him.
- There was no evidence that the Good Order and Discipline of the establishment was threatened (there were no other prisoners near, Mr Bayley was not occupying an area where prisoner movement was about to take place, there were plenty of staff about).
- The CM had not exhausted all available options for dealing with the situation.

We consider that the correct course of action in this case was for the CM to call the Orderly Officer or Duty Governor and treat the incident as a planned use of force.

163. We understand that the CM thought the arrival of extra staff would be intimidating for Mr Bayley and that a planned use of force was not appropriate because Mr Bayley was on an open landing. We do not consider that summoning either the Orderly Officer or the Duty Governor need have been intimidating. It might equally have signalled to Mr Bayley that his problem was being taken more seriously. Neither PSO 1600 nor the current policy framework place any limitation on the location of the prisoner when considering a planned use of force.

164. There were a number of advantages to a planned use of force. It would have given Mr Bayley a new (more senior) person with a fresh perspective to talk to, he would have been given straight choice between returning to his cell or being subjected to force, the required nurse would have had an opportunity to consult his medical records and identify his existing health conditions and the incident would have been recorded from start to finish on BWVC and a handheld camera.

165. We appreciate that the CM listened to Mr Bayley's concerns about his cell and made efforts to show Mr Bayley that he took him seriously and to resolve the issue for him. However, we consider the use of guided holds was not indicated in this case as there was no evidence that they were needed in direct response to a risk to the officers or to others. At the point the CM and Officer B tried to take his arms, Mr Bayley was backed into a corner with the three officers standing very close to him and he appeared under some stress. Neither of the officers was able to use the correct angle of approach to take Mr Bayley's arms. We consider it unsurprising that Mr Bayley reacted unfavourably to two officers reaching out to take hold of him, however peaceful their intentions.

166. Although we think the CM was wrong to attempt guided holds, we also think that their failure did not mean that further force was inevitable. When Mr Bayley's first

reaction was to tense up and began to resist staff, they had the choice to withdraw and think again. Instead, they appeared to try harder to get hold of his arms which in turn caused Mr Bayley to increase his resistance.

167. We have considered whether any specific recommendation in relation to the initiation of the use of force on Mr Bayley is required - given that it set off a chain of events that culminated in Mr Bayley's death. Our investigation has not revealed evidence to suggest that there is a systemic issue with the initiation of use of force at Pentonville and the use of force against Mr Bayley was referred to NIMU for investigation. The proper initiation of the use of force, while reliant on good staff training, appropriate leadership and a positive staff culture is, ultimately, dependent on staff judgement. We conclude that the CM's judgement was not so flawed as to merit a recommendation.

E2 sterile area

168. PSO 1600 advised that it was extremely important that staff involved in applying restraints or using force of any kind were aware of the signs and symptoms that may indicate that a prisoner is in medical distress. Annex D offered further guidance on serious medical conditions, including sickle cell anaemia, that were relevant to the use of force on a prisoner because of their effect on the oxygen content in the body. It noted that sickle cell disease was common in black populations and advised that staff should always consider the possibility of sickle cell disease when using force on black prisoners.

169. The PSO listed physical signs that a prisoner might be in distress, including sudden, abnormal passivity. The relocation of a prisoner was identified as a situation that should be particularly closely monitored to ensure that the prisoner was not in a physically distressed condition.

170. The first sign that Mr Bayley was in physical distress was in E2 sterile area. Mr Bayley was being moved in the underhook position which meant he was bent forward from the waist at a 90-degree angle with his hands cuffed behind his back. Even for someone without an underlying medical condition this is an uncomfortable position that affects breathing and puts the person under physical stress.

171. We think it is clear from CCTV that Mr Bayley appeared to be struggling physically and that he was unable to continue walking, rather than deliberately being obstructive as the officers moving him thought. We understand that it might not be easy to tell the difference in these situations and the officers who had control of Mr Bayley's arms and head were not best placed to see what had happened. Mr Bayley's initial response to Officer C reinforced their opinion. This is why relocations under restraint are supervised by the Orderly Officer and observed by a nurse.

172. When Mr Bayley stopped walking, the nurse was several feet away talking to a colleague in the Centre and looking in the opposite direction. We do not consider that she properly discharged her role to monitor the situation and assess Mr Bayley's safety. The Orderly Officer also bears a responsibility for monitoring the prisoner and we consider that the nurse should have been asked to assess Mr Bayley at this point.

173. Less than 30 seconds after he collapsed to his knees, Mr Bayley was picked up using an incorrect carry technique that left him face down. Mr Bayley almost immediately complained of difficulty breathing. The nurse was present at this point but made no attempt to assess Mr Bayley. Although she moved slightly closer for a better look when he was placed back on the floor, she was still some feet away and there were several officers surrounding Mr Bayley. We consider that she should have intervened to properly assess Mr Bayley and that the staff supervising the restraint should also have asked her to assess him.

174. We have not seen any evidence that any of the staff involved in the use of force, including the nurse, considered that, as a black prisoner, Mr Bayley might have sickle cell disease or understood the implications of this for restraining him. Had they done so, his collapse and struggle for breath in E2 sterile area should have raised extra concern and prompted ongoing monitoring. We discuss the role of healthcare in more detail below.

175. We are concerned that the specific requirement in PSO 1600 for staff to consider the possibility of sickle cell when restraining a black prisoner is not replicated in the current guidance issued to staff with the Use of Force Policy Framework. This is especially concerning as not only are black prisoners over-represented in the prison population but HMIP's thematic review *The experiences of adult black male prisoners and black prison staff* published in December 2022 showed that statistically black prisoners accounted for disproportionately more use of force incidents. We make the following recommendation:

The Head of Policy and Capability in the Security Directorate of HMPPS should amend the Use of Force Policy Framework to include the particular references to sickle cell disease that were contained in PSO 1600 and ensure that national use of force initial and refresher training includes information about sickle cell disease.

176. Pentonville referred the use of force against Mr Bayley to NIMU after his death. The member of NIMU's report made a number of recommendations about training that the prison has not acted on. We make the following recommendation:

The Governor of HMP Pentonville should implement the recommendations made in the NIMU report on the use of force against Mr Bayley within three months of this report.

Move from CSU to IPU

177. We consider that the CSU SO and the healthcare officer treated Mr Bayley with evident compassion when escorting him to the IPU. The evidence indicated that this was a planned removal given the number of staff present, the presence of the duty governor and the fact that another SO attempted to turn on his BWVC. However, there was no nurse present as required in a planned removal and there is no evidence one was requested. We consider that this was a missed opportunity for a healthcare professional to observe Mr Bayley's physical condition. When he left his cell on the CSU, Mr Bayley appeared frail and manifestly unwell, in stark contrast to the man who first had approached the CM on G Wing some seven hours previously.

178. We asked Pentonville for data on the presence of healthcare staff at planned use of force incidents. They told us that between 1 March 2024 and 31 May 2024, there were 24 planned uses of force and on 20 occasions (83%), healthcare staff were present. As a result, we make no recommendation, but the Governor will wish to repeat the analysis regularly (including considering the specific context of the incidents) to assure himself that healthcare staff are present.

Segregation

179. The initial process for all prisoners placed in the segregation unit is the same. The initial segregation health screen must be completed by a registered doctor or nurse within two hours and then the duty governor must authorise segregation based on the outcome of the health screen. The initial segregation health screen is the first step in the segregation process and until it is completed, none of the required actions that follow it can take place.

180. The nurse said she was unable to complete the health screen because she could not determine whether or not Mr Bayley was mentally fit to be segregated. She said she advised the CSU staff that they should ask a mental health nurse to assess him. The CSU SO and the Duty Governor both said they understood that the nurse would return to the CSU within the two hour period allowed for completion of the health screen. The evidence indicates that the nurse did not make herself sufficiently clear to the Duty Governor and the CSU staff. Had she done so, the CSU SO would not have spent some time attempting to contact her that afternoon.

181. The CSU SO did not manage to speak to the nurse before the two-hour window elapsed at 2.37pm. There is evidence that he asked a senior prison manager for advice at the end of the two-hour window, but this did not resolve the issue of the incomplete health screen. At this point a decision should have been taken. Mr Bayley had not been deemed fit for segregation and therefore needed to be moved. The CSU SO should have escalated the problem, especially in the light of Mr Bayley having defecated in his cell and remained naked and mostly unresponsive to officers since his arrival. He should have made the duty governor and the orderly officer aware of the issue. It was also open to him to contact the healthcare manager direct and ask for another nurse to come to the CSU. Instead, he appears to have continued to attempt to speak to the nurse until shortly before 4.00pm.

182. The nurse’s failure to complete the initial health screen and to make it clear she did not intend to return and the CSU SO’s failure to escalate the situation when the two-hour window elapsed, meant that it was some three and a half hours before it was confirmed by the duty mental health nurse that Mr Bayley was unfit for a period of segregation (although the health screen was in fact never completed). In total he spent a period of just under seven hours in segregation when he was not fit to do so. We understand the pressure on space in Pentonville and the demand for spaces on the IPU meant that it was not possible to move Mr Bayley immediately, however on a purely human level we do not consider that this was acceptable.

183. The prison day runs to a strict regime and there are certain times when there are many fewer staff available to undertake duties such as assessing and moving prisoners. The delay in determining whether Mr Bayley was fit for a period of segregation resulted in him being assessed by the duty mental health nurse shortly

before she went off duty. This in turn meant she did not take the time to read Mr Bayley's clinical record before she saw him and spent very little time attempting to assess him on the CSU. Further, the delay resulted in Mr Bayley being moved to the IPU during ED at the end of the main day shift there. The IPU nurse was not prepared for his arrival, the healthcare officer was trying to record the different prisoner moves and make his routine checks for evening roll count. All of these factors had further serious ramifications for the care Mr Bayley received that day.

184. There were other weaknesses in the segregation record keeping. There was a single retrospective entry on Mr Bayley in the CSU observation book written after he had moved to the IPU. Several staff referred to Mr Bayley as being on a dirty protest, but a dirty protest log was not completed (or if it was, the prison could not later locate it and we did not see it). The first entry on the CSU regime monitoring paperwork was not until 2.00pm and it erroneously recorded that Mr Bayley was given a teatime meal at 4.30pm.

185. The senior manager in charge of the CSU said that since Mr Bayley's death, quality assurance (QA) processes had been introduced to the CSU in the form of a new reception checklist and a supervising officer QA checklist. This ensured the completion of segregation health screens within the two-hour time limit. While we want to underline the seriousness of the failure to complete a segregation health screen in Mr Bayley's case, we accept that Pentonville has introduced measures that appear to be effective. The Governor will want to closely monitor these innovations over time to ensure prisoners are not unlawfully segregated.

The segregation safety algorithm

186. In 2023, we were asked to contribute to the initial consultation for the forthcoming Segregation Policy Framework which will replace PSO 1700. Based on the findings from a number of our investigations we raised concerns about the suitability of the safety algorithm that forms the backbone of the initial segregation health screen. In particular we are concerned that the narrowness of the yes/no questions do not encourage staff to consider all relevant factors across the prisoner's mental and physical health. The questions predominantly relate to the person's mental health and the number of physical health conditions, highlighted in PSO 1600 (and the use of force policy framework) are not mentioned.

187. We consider that this omission is not logical given the likelihood that prisoners subject to use of force are more likely than others to be taken to the segregation unit. There is no mandatory requirement for the nurse completing the health screen to refer to the prisoner's clinical record and there is no guidance on taking clinical observations or employing the National Early Warning Score (NEWS2) to identify patients whose health is deteriorating. All three of these are likely to be far more effective in identifying whether a prisoner is mentally and physically fit for segregation compared to simply looking at someone, which is what happened in this case. We make the following recommendation:

The Head of Security, Procedures and Capability in the Security Directorate of HMPPS should amend the guidance on completing the initial segregation health screen to:

- **make assessment of a prisoner's physical health as important as assessment of their mental health;**

- **make it mandatory for the nurse completing the health screen to check the prisoner's clinical record for the health conditions listed in the Use of Force Policy Framework (including sickle cell disease); and**

- **ensure that physical assessment includes a set of physical observations (blood pressure, temperature, oxygen saturation, pulse and respiratory rate) or assessment using NEWS2.**

Clinical care

188. The clinical reviewer has highlighted a number of deficiencies in the clinical care extended to Mr Bayley. Including:

- Despite having epilepsy and sickle cell anaemia he was not referred to the long-term conditions team.

- Apart from visual observations, the nurse did not make any attempt to assess Mr Bayley's physical condition after he complained of breathing difficulties during his removal to the CSU.

- Mr Bayley's condition was not adequately evaluated to determine whether he was fit and well enough to cope with a period of segregation.

- The nurse did not consider or try to establish whether there were physiological reasons why Mr Bayley was not responding to her questions.

- The nurse did not review Mr Bayley's medical records when considering whether he was fit for segregation.

- Mr Bayley's physical observations were not taken on arrival at the IPU, contrary to IPU operating procedures.

- From 9.00pm, Mr Bayley's visual observations were completed by an operational support grade without the clinicals skills to identify a deterioration in a prisoner's physical or mental health.

- Mr Bayley's medical records were not merged as they should have been when he arrived at the prison.

189. The clinical reviewer concluded that Mr Bayley's clinical care was not of the required standard and did not meet the standard of equivalence with clinical care in the community.

190. We are especially concerned by the failure to properly assess Mr Bayley's physical condition when he twice complained that he was having difficulty breathing (on E2 and on arrival in the IPU) and in response to his request to see a doctor on the IPU. We consider that none of the healthcare staff who encountered Mr Bayley on 17 May demonstrated an adequate level of professional curiosity or clinical focus. Further, nobody looked properly at his medical record to obtain a holistic picture of

his clinical history. Everyone relied on information passed to them by word of mouth and nobody questioned it. Mr Bayley was dismissed as non-compliant and then mentally ill. He was described as aggressive, which he had not been. Staff on the IPU were told he had been restrained but nobody asked how recently. Too many assumptions were made and too few questions were asked. This amounted to successive failures in the duty of care to Mr Bayley.

191. The clinical reviewer has made a number of recommendations related to the issues in Mr Bayley's care. Some are not directly related to Mr Bayley's death, but the Head of Healthcare will want to consider and address them. We repeat the following recommendations:

The Head of Healthcare should ensure that all members of the healthcare team receive supplementary training on their roles and responsibilities with regards to physical health checks and paperwork that should be completed when deciding whether a prisoner is fit for admission to the segregation unit.

The Head of Healthcare, in conjunction with the Governor, should ensure that healthcare staff can access prisoners' medical records from a device in the segregation unit.

192. During the investigation, Practice Plus Group (the healthcare provider at Pentonville) informed us of changes to practice and process since Mr Bayley's death. They said that clinical observations are always taken when a prisoner arrives on the IPU, no matter the hour of arrival. Nurses are now responsible for all health checks on inpatients. We welcome these developments. After Mr Bayley's death Practice Plus Group conducted their own review of events and produced a comprehensive report. The Head of Healthcare will want to assure herself that all of the recommendations in that report have been addressed.

Body-worn video cameras (BWVC)

193. In May 2022, guidance to staff on using their body-worn video cameras was contained in PSI 04/2017 *Body Worn Video Cameras*. It was mandatory for staff to use BWVCs at any reportable incident (as set out in PSI 11/2012, *Management and Security of the Incident Reporting System*) and staff were advised to start recording at the earliest opportunity to maximise the material captured by the camera. This guidance was replaced by the *Body Worn Video Cameras (BWVC) Policy Framework* in September 2022, although the requirement for staff attending incidents (including a spontaneous use of force and a medical emergency) to switch on their cameras remained the same.

194. In addition, the operational guidance on the use of rigid bar handcuffs in operation at the time of the use of force on Mr Bayley stated:

"Wherever practicable, staff wearing Body Worn Video Cameras should turn them on (or ask others present to do so) to record the events leading up to the use of rigid bar handcuffs. Once turned on, recording must continue until the incident is fully resolved and the prisoner has been relocated."

195. Using BWVC supports accountability and shows openness and transparency when talking to prisoners. Using BWVC also supports the review process and staff

learning. In our investigation into a death at Pentonville in July 2020, we recommended that the Governor should ensure that staff activate their BWVCs at the earliest opportunity during any reportable incident in line with that guidance. In their action plan, received in September 2021, the prison said that all staff were already reminded over the radio net to activate their BWVCs when attending a reportable incident. Orderly Officers also reminded staff of this requirement each day when overseeing the issuing of BWVCs. The use of BWVCs was monitored at the monthly safety meeting to identify activation levels and where it was identified that BWVCs had not been activated as they should have been, informal advice and guidance is issued to the staff involved.

196. Despite this, there were clearly still a number of issues with the BWVCs in operation at the time Mr Bayley died. A CM said he was not in the habit of collecting one every day and the cameras did not always work. A SO said in his experience the cameras were either not working at all or stopped recording after a few seconds. We have not seen any evidence that staff were given informal advice and guidance to use their BWVC after this incident. Two months after Mr Bayley died, HMIP found that staff only used BWVCs in about half of use of force incidents at Pentonville.

197. Of the three staff that initiated force on Mr Bayley, only Officer B was wearing a BWVC, and the recording cut off after a few seconds. A significant number of staff responded to the incident and CCTV showed several of them had BWVCs, however no one turned their camera on as they should have done. None of the staff who attended the emergency response activated their cameras and the lack of CCTV and radio transmissions means that we do not know if anyone was wearing a camera or if the control room reminded them to turn them on. BWVCs record audio as well as video and would have allowed a much greater understanding of events in this case not only for this investigation, for the Coroner's inquest to come and for learning but, importantly, for answering questions for Mr Bayley's family.

198. New BWVCs were introduced in Pentonville in 2023. The digital onsite support engineer told the investigator that he had not received any reported faults with individual cameras since the new system was introduced. Although evidence suggests that the current BWVCs in operation are more reliable, the efficacy of the system relies on staff turning them on when they should. In all of the three deaths since Mr Bayley died, staff responding to the emergency activated their BWVCs. We are satisfied that staff are now reminded effectively to turn on their BWVC during emergency responses.

199. The investigator asked HMIP for current statistics on the use of BWVCs in use of force incidents at Pentonville. In March 2024, BWVCs were used in 66% of incidents. This dropped to 65% in April and 60% in May 2024. HMIP told us that some prisons achieve into the 90% range. On that basis, we consider that this is still a systemic issue at Pentonville and make the following recommendation:

The Prison Group Director for London should write to the Ombudsman setting out how the use of BWVC at Pentonville is being embedded and monitored.

Mr Bayley's cell on G Wing

200. We do not consider that cell G4-21 was fit for occupation on 16 May 2022. Not only is not acceptable for prisoners to be moved to dirty and untidy cells, it might have serious consequences for their mental and physical health. Mr Bayley's sickle cell anaemia meant that it was especially important that he avoid dirty environments to help prevent infection. In our investigation into the self-inflicted death of a prisoner at Pentonville in 2019, we found that, the night before he died, he was moved to a cell that was unfit for habitation generally and was a particularly unsuitable environment for someone vulnerable and at risk of suicide or self-harm. It is therefore especially troubling to investigate a second death which involved a prisoner moving to an unfit cell the day before.

201. The evidence indicates that Mr Bayley pressed his cell bell three times in relatively quick succession after moving to G4-21 and that it was answered by staff each time. While we do not know for certain what exchanges he had with staff that afternoon, we consider it is a reasonable conclusion, given the CM's evidence that Mr Bayley said he had unsuccessfully attempted to resolve the issue with wing staff, that these calls related to the condition of his cell. The issue had clearly not been resolved by the time he spoke to the CM the following lunchtime. At the time, prisoners at Pentonville usually spent 23 hours a day in their cells. The fact that, by the time Mr Bayley spoke to the CM he had already spent some 19 hours in an environment he knew to present a danger to his health, might go some way to explaining his agitation when speaking to the CM and his extreme reluctance to return to his cell.

202. In 2020, in response to our recommendation in the 2019 death referred to above, Pentonville said that the prison had begun implementing a pre-occupancy decency check in all residential areas. Any cells deemed unfit to be occupied would not be allocated until work had been carried out to meet the decency criteria.

203. At interview in May 2024, the CM said that due to the lack of cell spaces, induction unit staff were very quick to move prisoners to cells to wings as soon as spaces arose and sometimes did not wait for wing staff to ensure the cell was clean. In 2022 and 2023, HMIP expressed serious concern that Pentonville was severely overcrowded and could not safely or decently care for the number of prisoners it was required to hold. The IMB raised their concerns about overcrowding with the Secretary of State for Justice. This situation has unfortunately not improved at the time of writing in 2024 and is unlikely to for the foreseeable future. Given the population pressures, it is all the more important that the prison has an efficient and effective procedure for ensuring cells are cleared and cleaned between occupants. We make the following recommendation:

The Governor of HMP Pentonville should introduce a quality assurance regime to satisfy himself that the pre-occupancy decency checks are taking place in all residential areas.

Emergency response

Code blue and ambulance call

204. The evidence we have seen suggests that the night nurse radioed a code blue emergency and asked for an ambulance at about 10.40pm. It does not appear that an ambulance was called until the night orderly officer radioed a second code blue at 10.44pm. There was a further delay in paramedics attending Mr Bayley because the control room officer initially directed the ambulance to the wrong gate.

205. We do not think that these delays changed the outcome for Mr Bayley, but such a delay might prove crucial in another case. In our investigation into a death at Pentonville in July 2023 there was also a four minute delay in calling an ambulance, although for different reasons.

206. As we have not seen any evidence of a current systemic issue with calling ambulances, we bring this to the Governor's attention but make no recommendation.

Resuscitation

207. The reported stiffness in Mr Bayley's jaw and hands when the night nurse examined him meant that resuscitation was likely to be futile. We note that signs unequivocally associated with death including rigor mortis and blood pooling were not immediately apparent and that paramedics continued resuscitation for some time after they arrived. The acting Head of Healthcare has confirmed that nasopharyngeal airways are now contained in every emergency bag in the prison along with oropharyngeal airways (known as Guedel airways) and supraglottic airways (known as I-gel airways). We therefore make no recommendation.

Substance misuse

208. The toxicology report showed that Mr Bayley had used cannabis at some time prior to his death. The forensic scientist who analysed the results said the levels found suggested relatively recent use, although as levels increased post-mortem, they might represent less recent use if Mr Bayley were a regular or heavy user of the drug. He added that, if Mr Bayley had used cannabis in the hours before his death he might have been experiencing some of the effects although the level was non-toxic. We have not seen any evidence that Mr Bayley used or was suspected of using cannabis in the six days he was at Pentonville, and we know that he had not used it in at least the almost 11 hours before he was found not breathing in the IPU.

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