Prisons & Probation Ombudsman
Independent Investigations

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Independent investigation into the death of Mr Chandler Bailey, a prisoner at HMP Lewes, on 4 January 2021

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Our vision

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

Our values

We are:

Impartial: we do not take sides

Respectful: we are considerate and courteous

Inclusive: we value diversity

Dedicated: we are determined and focused

Fair: we are honest and act with integrity

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

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

Mr Chandler Bailey was found hanged in his cell at HMP Lewes on 4 January 2021. He was 23 years old. I offer my condolences to Mr Bailey's family and friends.

Mr Bailey was recalled to custody on 21 December 2020. Staff assessed that he was not at risk of suicide and self-harm when he arrived. However, on 3 January, an officer found a potential ligature (made from strips of bedsheet tied together) in Mr Bailey's cell. When asked about it, Mr Bailey said he had made it because he was bored. The next morning, Mr Bailey was found hanged in his cell.

I am concerned that neither the officer who found the potential ligature nor the supervising officer he discussed it with, properly considered whether suicide and self-harm prevention procedures should be put in place for Mr Bailey. This was a missed opportunity. I am also concerned that staff did not record this incident in Mr Bailey's prison record.

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

Sue McAllister CB
Prisons and Probation Ombudsman **February 2022**

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Summary

Events

1. On 15 December 2020, Mr Chandler Bailey was released from HMP Lewes on licence. On 21 December, he was recalled to prison custody and returned to Lewes. As a new arrival, he was required to isolate for 14 days under the COVID-19 requirements. Staff assessed that Mr Bailey was not at risk of suicide or self-harm.

2. Night staff told us that Mr Bailey's behaviour was strange as talked to himself and regularly used his cell bell and asked to be let out of his cell. They said day staff told them this was 'normal' for Mr Bailey.

3. At lunchtime on 3 January 2021, an officer found a potential ligature (strips of bedsheet tied together) in Mr Bailey's cell. Mr Bailey told him he had made it because he was bored. The officer spoke to a supervising officer and they agreed that Mr Bailey was not at risk of suicide or self-harm.

4. At around 5.00am on 4 January, an operational support grade (OSG) carried out a roll check (count of prisoners), but he did not look into Mr Bailey's cell. He said he heard Mr Bailey talking to himself, so was satisfied he was alive in his cell.

5. At 9.10am, an officer, accompanied by a nurse, found Mr Bailey hanging in his cell toilet. The officer called a medical emergency code while the nurse cut Mr Bailey down. It was clear that Mr Bailey was dead, so staff did not try to resuscitate him.

Findings

6. There is no record that staff had any meaningful engagement with Mr Bailey during his two weeks at Lewes

7. Although staff told us that Mr Bailey's behaviour was "unusual", this was not recorded at the time or reported to healthcare.

8. Staff failed to properly assess Mr Bailey's risk of suicide and self-harm when they found a potential ligature in his cell the day before he died. They also failed to record this incident and a previous incident in Mr Bailey's prison record.

9. We are satisfied that Mr Bailey was alive when the roll check was carried out at around 5.00am on 4 January. The prison gave the OSG written advice and guidance for failing to carry out a visual check of Mr Bailey during the roll check.

10. Under a normal regime, staff would have unlocked Mr Bailey by 8.00am and checked on his welfare. However, under the restricted COVID-19 regime, prisoners were not unlocked until much later. Mr Bailey was not checked until 9.10am, when an officer and a nurse went to check whether he had any COVID-19 symptoms before moving him to a standard wing. Mr Bailey had been dead for some time when found and it is unlikely that an 8.00am welfare check would have altered the outcome, but the lack of a morning welfare check was a concern. Since Mr Bailey's death, Lewes has reintroduced morning welfare checks on all prisoners.

11. Although staff cut the ligature when they found Mr Bailey hanging, they did not remove it from his neck and left him in the toilet area. Mr Bailey was not moved until the prison paramedic arrived, and the ligature was not removed until ambulance paramedics arrived.

Recommendations

- The Governor should ensure that all staff have a clear understanding of their responsibilities to manage prisoners at risk of suicide and self-harm in line with national guidelines and, in particular, the need to record, share and consider all information about risk, and start ACCT procedures where appropriate.
- The Governor should ensure that staff engage with prisoners during the pandemic and are alert to signs that a prisoner may be struggling with mental wellbeing.
- The Governor should share a copy of this report with Officer A and arrange for a senior manager to discuss the Ombudsman's findings with him.
- The Governor should:
  - share a copy of this report with the A Wing SO and arrange for a senior manager to discuss the Ombudsman's findings with him; and
  - arrange refresher training for the A Wing SO on recognising and assessing prisoners' risk of suicide and self-harm.
- The Governor should ensure that staff understand their responsibilities when they discover a prisoner hanging, in particular that they:
  - cut the ligature from the ligature point;
  - remove the remnant of the ligature from the prisoner's neck; and
  - move the prisoner if they are in a confined area.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Lewes informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

13. The investigator obtained copies of relevant extracts from Mr Bailey's prison and medical records. He interviewed 21 members of staff and two prisoners at Lewes between February and June 2021. All the interviews were conducted by telephone due to the COVID-19 pandemic.

14. NHS England commissioned a clinical reviewer to review Mr Bailey's clinical care at the prison. The investigator and clinical reviewer jointly interviewed clinical staff.

15. We informed HM Coroner for East Sussex of the investigation. The Coroner gave us Mr Bailey's cause of death. We have given the Coroner a copy of this report.

16. One of the Ombudsman's family liaison officers contacted Mr Bailey's next of kin, his father, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. Mr Bailey's father contacted the investigator direct and said that when he visited his son's cell after his death, he was suspicious that the cell was so tidy. Mr Bailey's father also wanted to know whether the prison adequately assessed his son's mental health needs.

17. We shared the initial report with Mr Bailey's father and with HM Prison and Probation Service (HMPPS). They identified that we had misspelled the name of one of the officers. They also pointed out that Mr Bailey was not self-isolating at the time of his death and asked that we recast our finding at paragraph 57 and to reword our associated recommendation. We agreed these changes.

Background Information

HMP Lewes

18. HMP Lewes is a local prison serving the courts of East and West Sussex and holds up to 692 men. Sussex Partnership NHS Foundation Trust provides primary care services. HMP Lewes has a healthcare centre with a full-time senior medical officer. Healthcare is provided on a 24-hour basis; there is a 12-bed inpatient unit, an outpatient facility, a pharmacy and a range of clinics.

HM Inspectorate of Prisons (HMIP)

19. The most recent inspection of HMP Lewes was in January 2019. In his introduction, the Chief Inspector said that the findings of the inspection were deeply troubling and indicative of systemic failure. He wrote that in the key area for assessment - safety - the prison's performance was heading towards the lowest possible assessment rating. The report also noted that there had been five self-inflicted deaths in the three years since their previous inspection, and that despite comprehensive action plans in response to Prisons and Probation Ombudsman recommendations, most recommendations had not been satisfactorily implemented. For prisoners identified as being at risk of suicide or self-harm, inspectors found many instances where case reviews were not multidisciplinary, leading to a poor assessment of risk. They recommended that the prison implement a strategy to reduce self-harm based on data analysis and the delivery of good care for those at risk of suicide and self-harm through the ACCT process.

20. HMIP conducted an Independent Review of Progress at Lewes in December 2019 to review progress since the earlier inspection. Inspectors concluded that, overall, the review was promising, and that the Governor and her senior managers were taking the prison in the right direction.

21. They considered that the prison had made reasonable progress against the self-harm recommendation. The number of self-harm incidents had declined by over a third in the previous six months compared to a similar period before the inspection, and there had been one self-inflicted death since the inspection. Managers had analysed local self-harm data and written a comprehensive self-harm prevention strategy and plans were in place to implement the new strategy early in 2020 following final consultation with prisoners and staff. Inspectors also reported that ACCT procedures were regularly quality assured but still required improvement. Case notes still lacked sufficient detail and, while health care staff attendance had improved, not all case reviews were sufficiently multidisciplinary.

Independent Monitoring Board

22. 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 published annual report for the year to January 2020, the IMB reported that it had seen many examples of staff treating prisoners with humanity, kindness and great patience. However, the Board also noted that there had been major failings in the regime offered to prisoners, including frequent lockdowns.

Previous deaths at HMP Lewes

23. Mr Bailey was the fifth prisoner to die at Lewes since January 2019. Of the previous deaths, three were from natural causes and one was self-inflicted. Our investigation into the self-inflicted death found that despite a number of clear risk factors, staff did not start suicide and self-harm prevention measures.

24. There have been two self-inflicted deaths since Mr Bailey's death, which we are still investigating.

Assessment, Care in Custody and Teamwork

25. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary case reviews involving the prisoner. Checks made on prisoners should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

25 April – 15 December 2020

26. On 25 April 2020, Mr Chandler Bailey was arrested and taken to HMP Lewes for breach of a restraining order. This was his third time at Lewes in six months.

27. From the end of May, Mr Bailey began displaying unusual behaviour where he would remain motionless and unresponsive for extended periods of time. He also began to neglect his personal hygiene and he began to hoard food, leading to weight loss. Mr Bailey's unusual behaviour continued over the following months and medical staff at Lewes suspected a psychotic illness. Mr Bailey was monitored using suicide and self-harm prevention procedures (known as ACCT) to help assess his food and fluid intake and whether he might be at risk through self-neglect.

28. On 13 August, Mr Bailey was admitted to a secure mental health hospital for assessment. A hospital discharge summary noted that Mr Bailey's antipsychotic medication had been stopped on 25 August to allow proper assessment of his mental health and over the following month, staff observed no objective sustained signs of psychosis or mood disorder. The hospital concluded that Mr Bailey appeared to be producing false or exaggerated psychological symptoms to avoid being sent back to prison.

29. Mr Bailey was returned to Lewes on 1 October. ACCT procedures were opened again on 5 November, due to concerns that Mr Bailey was again neglecting himself. The ACCT was closed on 27 November as the healthcare and mental health teams were content that there were no further concerns.

30. Mr Bailey remained at Lewes until he was released on licence on 15 December.

21 December onwards

31. On 21 December, Mr Bailey was again arrested for breaching a restraining order and he was again returned to Lewes.

32. A nurse carried out Mr Bailey's reception health screen. She told the investigator that she had treated Mr Bailey both before and after his period in the mental health hospital and he had joked with her on 21 December about returning to custody. She said that Mr Bailey had put on weight, he was looking well, and he said that he had no thoughts of harming himself.

33. A Supervising Officer (SO) was in reception and spoke to Mr Bailey. He had had extensive dealings with Mr Bailey from his previous time in custody and had been the case manager when Mr Bailey's last ACCT plan had been closed. He told the investigator that he and Mr Bailey had chatted for five to ten minutes on 21 December and Mr Bailey was in good humour.

34. Mr Bailey was moved to A Wing, the induction wing. An officer told the investigator that she had had contact with Mr Bailey during his previous times in custody, including times when he was unresponsive to staff, was eating poorly and was neglecting his personal hygiene. She said that in this final period in custody he

engaged with the prison regime, including taking showers and going to exercise. She said that he gave no indications that he might be at risk of deliberate self-harm.

3 January 2021

35. During the late morning on 3 January, staff began unlocking cells for prisoners to collect lunch. CCTV shows Officer A going into Mr Bailey's cell and coming out with a piece of material in his hand. When asked about this at interview, he told the investigator that his practice was to go into prisoners' cells while they were unoccupied to check if he could see anything untoward. He went into Mr Bailey's cell while it was empty, and he found a strip of material (pieces of bedsheet tied together) on top of the cupboard. He walked towards the servery and walked back with Mr Bailey who was returning with his food. He said he asked Mr Bailey about the strips of bedsheet tied together and Mr Bailey just smiled and said that he had made it through boredom. He told the investigator that he had only known Mr Bailey during his final period in custody. He said that Mr Bailey was "unusual", and that it was difficult to make conversation with him. However, Mr Bailey was no different on 3 January to his usual self and he (Officer A) considered that he was not at risk of harming himself.

36. Officer A said that he spoke to the A Wing SO and gave him the strip of material. The A Wing SO asked him if he had any concerns for Mr Bailey's safety and he said that he had no concerns. (Officer A acknowledged at interview with the investigator that it would have been appropriate to have opened an ACCT for Mr Bailey.)

37. The A Wing SO told the investigator that he could not recall Officer A giving him a strip of material that he had taken from Mr Bailey. He said that it was common practice for prisoners to construct 'lines', which they typically used as washing lines, to make a belt or as a line to pass contraband to adjoining cells. He said that whenever officers brought him such items, he would discuss with the officer their assessment on indications the prisoner might be at risk of suicide and self-harm and whether an ACCT should be opened. He added that confiscated lines were disposed of with an oral warning to the prisoner about destruction of prison property. He said that further infringements would lead to warnings under the incentives and earned privileges (IEP) scheme. (Mr Bailey's records contain no IEP warnings for destruction of property or for constructing a line and no record that a potential ligature had been found in his cell.)

38. The investigator also asked the A Wing SO about the evidence of another officer, who said that while carrying out cell checks around a week before Mr Bailey died, he had found some 'string' (which was yellow in colour and looked like it had been taken from one of the prison blankets) on the floor of Mr Bailey's cell and that he had told the A Wing SO. The A Wing SO said that he had no recollection of that incident, but he would have applied the same principles as he did on 3 January.

39. An Operational Support Grade (OSG) told the investigator that he had worked a set of nights on A Wing, starting from the night of 28 December. Throughout the week Mr Bailey had rung his cell bell for various reasons, including to ask if he could be allowed out of his cell to wander around or to go to his car to collect some belongings. On the night of 3 January, Mr Bailey had asked for some activities and he had given him a 'distraction pack' containing a colouring book for adults. He said that he had spoken to day staff about Mr Bailey's unusual requests and had

been reassured that that was normal for him. He also said he had never had concerns that Mr Bailey was at risk of harming himself.

4 January 2021

40. At around 4.45am on 4 January, Mr Bailey rang his cell bell and an officer responded. The officer told the investigator that this was his last shift of a week of night shifts and that Mr Bailey had rung his cell bell throughout the week. Typically, Mr Bailey had either asked the time or had asked if he could go to his car to collect belongings. The officer said that despite his unusual questions, there was never anything about Mr Bailey's demeanour to suggest he might be at risk of harming himself.

41. At around 5.05am, the OSG made an early morning roll check. CCTV shows that he did not check Mr Bailey's cell, although he checked all the other cells. The OSG told the investigator that as he neared Mr Bailey's cell, he heard him talking to himself. He said it was not unusual to hear Mr Bailey talking to himself and, as he was assured Mr Bailey was alive, he did not look into the cell. He added that he was a little distracted that morning as another prisoner was engaged in a dirty protest and was disturbing the other prisoners by making a lot of noise. (On reviewing the CCTV, the investigator saw that the OSG looked at Mr Bailey's cell as he walked along the landing but did not look into the cell as he did with the other cells.)

42. Before the COVID-19 pandemic, all prisoners would have been unlocked by the day staff by 8.00am. Under the revised COVID-19 working practices, prisoners were allowed out of their cells in small groups staggered throughout the day. This meant that there was no process in place for a morning welfare check of all prisoners following the arrival on duty by the day staff.

43. At around 9.10am, an officer went to Mr Bailey's cell accompanied by a nurse so that he could check that Mr Bailey had no symptoms of COVID-19 before moving to a standard prison wing. When the officer opened Mr Bailey's cell door observation panel, she could not see him in the cell. She called his name but got no response. She then unlocked the door and stepped into the cell. She again called Mr Bailey's name, but again got no response. She stepped further into the cell, followed by the nurse.

44. The officer went to the cell toilet and saw Mr Bailey in a kneeling position on his toilet with his back towards her and hanging from a ligature tied to the ceiling-mounted smoke detector. She said to the nurse that she thought he was dead. She radioed a code blue emergency and stepped out of the cell to call for staff assistance. She then tried to draw her anti-ligature knife, but her hands were shaking too much. The nurse drew the knife from the officer's belt and cut the ligature. The officer said the ligature had been made from the edging of a blanket.

45. An SO arrived at the cell in less than 30 seconds in response to the code blue. He told the investigator that he went into the cell and saw Mr Bailey in the toilet. The nurse told him that Mr Bailey was dead. The SO said that the reason he did not move Mr Bailey into the main cell was because he was unsure of the protocol when a prisoner had been declared dead: he thought the protocol might be to leave the body in situ pending the arrival of police investigators or the Coroner's officer.

46. A second officer told the investigator that she responded to the first officer's call for staff assistance. When she went into the cell, a nurse was supporting Mr Bailey's body on the toilet. The ligature had been cut from the ligature point on the ceiling, but the remnant of the ligature was tight around Mr Bailey's neck. She said it was clear Mr Bailey was already dead. The nurse then left the cell to speak to the ambulance call handler and the second response officer was asked by the SO to support Mr Bailey's body. The second response officer told the investigator that she recognised in retrospect the Mr Bailey should have been moved out of the toilet and that the remnant of the ligature should have been cut from his neck.

47. A prison paramedic told the investigator that her role included responding to all emergency calls. She said that when she arrived on the wing there were several officers standing outside Mr Bailey's cell and there was another officer inside the cell (the second response officer). Mr Bailey was still in the toilet area so she asked the officer to move him to the main cell so she could examine him properly. She said that resuscitation was not appropriate as there were clear signs that Mr Bailey was dead: he was very cold, blood was pooling in his body and his jaw was stiff with rigor mortis. She saw a thin, yellow ligature tight around Mr Bailey's neck and assumed that officers had touched him as little as possible when they realised he was beyond help.

48. Ambulance paramedics arrived at around 9.24am and they asked for the ligature to be cut from Mr Bailey's neck. The SO cut the ligature. He told the investigator that the ligature was quite deep into Mr Bailey's flesh, and he had not noticed it when he initially responded to the emergency call. The paramedics confirmed that Mr Bailey was dead.

Contact with Mr Bailey's family

49. In line with Government advice on COVID-19 working practices, a prison manager telephoned Mr Bailey's father at 11.15am to tell him the news of his son's death. Lewes contributed to the cost of Mr Bailey's funeral in line with national instructions.

Support for prisoners and staff

50. The duty governor debriefed the staff involved in the response when Mr Bailey was discovered. The staff care team also offered support.

51. The prison posted notices informing other prisoners of Mr Bailey'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 Mr Bailey's death.

Post-mortem report

52. The post-mortem report gave Mr Bailey's cause of death as hanging. Toxicological examination found no drugs in his blood or urine.

Findings

Identifying risk of suicide and self-harm

53. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, sets out the risk factors and triggers that might increase a prisoner's risk of suicide and self-harm and sets out the procedures (known as ACCT) that staff must follow when they identify a prisoner at risk.

54. When Mr Bailey arrived at Lewes on 21 December 2020, reception staff assessed that he was not at risk of suicide and self-harm. They said he looked well and was in good humour. We consider that there was no reason to open an ACCT at that time.

55. However, we are very concerned that on 3 January, when a potential ligature, made from torn bedsheets, was found in Mr Bailey's cell, staff did not properly assess his risk of suicide and self-harm, nor did they record this incident. We are also very concerned that a previous discovery of a potential ligature around a week before, had not been recorded.

56. Both the officers who found the potential ligatures told us that they reported the finds to the A Wing SO (although he told us that he did not remember either of these incidents). We consider that the A Wing SO should have ensured that the incidents were recorded and should have recorded his reasons for not thinking it necessary to start ACCT procedures, particularly after the second potential ligature was found.

57. Due to COVID-19, prisoners have been required to spend more time in their cells isolated from other prisoners. Any feelings of isolation would have been exacerbated with Mr Bailey as he did not have a cellmate. We are concerned that there is no record of any staff engagement with Mr Bailey during the two weeks he spent at Lewes before his death when staff should have been checking on his mental wellbeing. We note that, although Mr Bailey's behaviour was considered "unusual" because he talked to himself and repeatedly asked to be let out of his cell to collect items from his car, this was neither recorded by staff and nor was it reported to healthcare staff. We note that Mr Bailey asked for a distraction pack the night before he died, which suggests that he was finding the isolation difficult. We consider that Mr Bailey's unusual behaviour should have been taken into account alongside the discovery of the potential ligatures when deciding whether to start ACCT procedures, particularly as he had been monitored under ACCT procedures as recently as November 2020.

58. The prison provided written advice and guidance to the officer who found the ligature on 3 January. Nevertheless, we make the following recommendations:

    The Governor should ensure that staff engage with prisoners during the pandemic and are alert to signs that a prisoner may be struggling with mental wellbeing.

    The Governor should share a copy of this report with Officer A and arrange for a senior manager to discuss the Ombudsman's findings with him.

The Governor should:

- **share a copy of this report with the A Wing SO and arrange for a senior manager to discuss the Ombudsman's findings with him; and**
- **arrange refresher training for the A Wing SO in recognising and assessing prisoners' risk of suicide and self-harm.**

Morning roll check

59. At 5.05am on 4 January, an OSG carried out a roll check on A Wing. CCTV shows that he checked all the cells apart from Mr Bailey's. The OSG can be seen looking at Mr Bailey's cell as he walked along the landing, but he did not look through the observation panel. He told the investigator that he heard Mr Bailey talking to himself, so he knew he was in his cell and was alive.

60. We note that an officer spoke to Mr Bailey at 4.45am. We are also aware that Mr Bailey did talk to himself, as the investigator heard him do so during a telephone call to his mother. We have no reason to doubt the OSG's evidence that Mr Bailey was alive and talking to himself at 5.05am, but we are concerned that he did not do a visual check on Mr Bailey. We are aware, however, that the prison gave him written advice and guidance about his failure to carry out a proper roll check, and therefore we make no recommendation.

Lack of welfare check

61. Under normal circumstances, the day staff would have unlocked Mr Bailey by 8.00am to offer him the use of some facilities. However, due to the COVID-19 pandemic the offer of use of facilities was being staggered throughout the day. In Mr Bailey's case, he was not checked by day staff until 9.10am when a nurse went to check to see if he was free of COVID-19 symptoms and was fit to move to a new wing.

62. Mr Bailey had rigor mortis when he was found at 9.10am. As rigor mortis occurs between two and six hours after death, it is likely that staff would have found him dead even if they had checked on him at around 8.00am. However, we are concerned that there was no process in place at the time to ensure a morning welfare check of prisoners after the arrival of the day staff. Since Mr Bailey's death, Lewes has implemented a full welfare check of all prisoners at the time of staff handover: both when day staff take over from night staff and when night staff take over from day staff. As the prison has already taken action, we make no recommendation.

Emergency response

63. When the officer and the nurse found Mr Bailey hanging in his toilet, they cut the ligature from the ligature point. However, Mr Bailey was not moved out of the toilet until the prison paramedic arrived and the remnant of the ligature was not cut away from his neck until the ambulance paramedics asked that this be done.

64. Staff were clearly confused about the actions they need to take when they discover a prisoner hanging. We make the following recommendation:

The Governor should ensure that staff understand their responsibilities when they discover a prisoner hanging, in particular that they:

- **cut the ligature from the ligature point;**
- **remove the remnant of the ligature from the prisoner's neck; and**
- **move the prisoner if they are in a confined area.**

Clinical care

65. The clinical reviewer found that Mr Bailey received a good standard of care at Lewes that was equivalent to that which he could have expected to receive in the community. In particular, healthcare staff were diligent in their attempts to engage with him during the time from May to August 2020 when he was exhibiting extreme behaviour and was neglecting his own care. The clinical reviewer made no recommendations.

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