

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Victor Cormello a prisoner at HMP Lewes on 18 May 2018

A report by the Prisons and Probation Ombudsman

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*



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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 I oversee can improve their work in the future.

Mr Victor Cormello died on 18 May 2018, of pneumonia, against a background of a stroke and heart disease. He was 87 years old. I offer my condolences to Mr Cormello's friends.

Mr Cormello presented with a number of complex health needs including extreme frailty and blindness. Despite these challenges, the care he received at HMP Lewes was equivalent to that which he could have expected to receive in the community.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman

December 2018

Contents

Summary	1
The Investigation Process	2
Background Information	3
Key Events	4
Findings.....	7

Summary

Events

1. On 20 December 2017, Mr Cormello was remanded into custody after being convicted of sexual offences. He was sent to HMP Lewes.
2. Mr Cormello was extremely frail, blind, hard of hearing and had had a heart attack in the past. After a nurse completed his first night screen, Mr Cormello was accommodated on a wing where there was a greater input from healthcare staff, and prisoners were able to assist the more vulnerable of the other prisoners. A prison GP prescribed an inhaler and medication for high blood pressure and cholesterol.
3. On 21 December, Mr Cormello was sentenced to four years imprisonment and was returned to Lewes.
4. On 6 January 2018, another prison GP saw Mr Cormello in his cell and was concerned about the suitability of the prison environment for such a frail person. The GP arranged for a social services assessment referral to be made.
5. On 9 January, Mr Cormello was admitted to hospital following a fall.
6. On 12 January, Mr Cormello had a stroke. His function was impaired and he remained in the care of hospital staff. Mr Cormello needed a full care package and 24-hour supervision.
7. On 8 March, Mr Cormello was released from Lewes on a special purpose licence issued on medical grounds and was accompanied by one escort. No restraints were used.
8. On 8 May, Mr Cormello was transferred to a Nursing Home. He died on 18 May 2018.

Findings

9. We are satisfied that the care Mr Cormello received at HMP Lewes was equivalent to that which he could have expected to receive in the community.
10. Mr Cormello was accommodated on a wing with enhanced support due to his frailty, medical and social care needs. Healthcare staff identified that the care and support Mr Cormello needed was beyond that which the prison could provide and appropriately referred him for a social care needs assessment.
11. Appropriately, restraints were not applied when Mr Cormello was admitted to hospital and subsequently to a nursing home.
12. We make no recommendations.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Lewes informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
14. The investigator obtained copies of relevant extracts from Mr Cormello's prison and medical records.
15. NHS England commissioned a clinical reviewer to review Mr Cormello's clinical care at the prison.
16. We informed HM Coroner for East Sussex of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.
17. The investigator contacted Mr Cormello's named next of kin to explain the investigation and to ask whether he had any matters he wanted the investigation to consider. He did not respond to our letter or request a copy of our report.
18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Lewes

19. 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 health care centre with a full time senior medical officer, which makes use of specialist NHS facilities when needed. Health care 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

20. The most recent inspection of HMP Lewes was completed in January 2016. The inspectors found that staff in the healthcare inpatient unit provided prisoners with complex health needs with care, but a lack of custody staff affected the development of a therapeutic regime.

Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to January 2018, the IMB reported a number of problems including staffing issues which were impacting the prison's ability to deliver a stable regime, and the building's Victorian fabric and design which made it difficult for staff to provide care to its increasing population of older prisoners. Healthcare applications had almost doubled with the three main issues being clinic and GP waiting times, cancelled hospital appointments, and a perceived failure to provide specific drugs.

Previous deaths at HMP Lewes

22. Mr Cormello was the fourteenth prisoner to die from natural causes at Lewes since June 2015. There were no significant similarities with the other deaths.

Key Events

23. On 20 December 2017, Mr Cormello was remanded into custody after being convicted of sexual offences. He was sent to HMP Lewes.
24. On his arrival at Lewes, a nurse conducted Mr Cormello's reception screen. Mr Cormello was 86 years old and the nurse recorded that he was very frail, unsteady, blind, diabetic, had hearing difficulties, had a history of heart attack and, while in the community, had a nurse visit him every evening to give him his medication. Mr Cormello's blood pressure was 133/75. (An ideal reading is 120/80 so this was only partially within the pre-high range.) Mr Cormello was accommodated on F wing where there was greater input from healthcare staff, regular attendance from outside agencies and help from prisoners who assisted other prisoners who were most vulnerable.
25. On 21 December, Mr Cormello was sentenced to four years imprisonment. He was sent back to HMP Lewes the same day.
26. On his return to Lewes, a prison GP reviewed Mr Cormello and recorded that he had prescribed clenil modulite (an inhaler), ramipril (for high blood pressure) and simvastatin (for high cholesterol). A nurse also saw Mr Cormello and noted that due to his poor vision he would need to have his medication supervised.
27. On 23 December, a prison GP prescribed aspirin and a GTN spray (glyceryl trinitrate eases the symptoms of angina). He asked for this to be given to Mr Cormello daily and administered by nursing staff, rather than by Mr Cormello himself.
28. On 4 January 2018, Mr Cormello reported that he had had a fall.
29. On 6 January, a prison GP saw Mr Cormello in his cell. Mr Cormello had a half-eaten plate of food and the prison GP had to guide his hand so he could find it. Mr Cormello showed him a tablet that he was about to take but which was, in fact, a cigarette stub. He was concerned about the suitability of the prison environment for someone with Mr Cormello's physical frailties. He sent an 'electronic task' (a request sent via healthcare's computer system) to a primary nurse to make a referral for a social services assessment. A business administrator, sent the referral on 8 January.
30. On 8 January, a prison GP emailed a nurse expressing his concerns about Mr Cormello and asked for advice about what they could do for him while he was waiting for his social services assessment. The nurse also saw Mr Cormello that day because a prisoner had raised concerns that Mr Cormello was unable to care for himself. She recorded that Mr Cormello reported being cold and that he had had a fall the week before. Mr Cormello retracted this claim very soon after saying it and he had no obvious injuries to suggest that he had fallen. Mr Cormello's cell was dirty and he was unkempt. She asked the wing officers to chase safer custody staff for social care input and also planned to do so herself.
31. On 9 January, a prison GP recorded that she saw Mr Cormello because he had fallen after using the toilet and had cut his hand. She examined him and his blood pressure reading was 165/72 and his pulse rate 71 beats per minute. Mr

Cormello had some light bruising to the base of his back and signs of a chest infection. She requested an ambulance to transfer Mr Cormello to hospital because she felt that his healthcare needs could not be met in prison.

32. Mr Cormello was admitted to the hospital that afternoon. A Governor authorised that no restraints were to be used and Mr Cormello was escorted by two officers. Healthcare staff maintained contact with hospital staff although there were no plans for Mr Cormello to be discharged from hospital.
33. On 17 and 20 January, a nurse contacted the hospital for an update on Mr Cormello's progress. She recorded that the hospital had informed her that Mr Cormello had had a stroke. (This was confirmed by a scan taken on 12 January.) It had affected his ability to swallow and walk. Mr Cormello's confusion accelerated, and prison healthcare staff reiterated to hospital staff how unsuitable HMP Lewes would be for Mr Cormello if he were to be discharged from hospital. An occupational therapist at the hospital confirmed that Mr Cormello would need a full package of care and 24-hour supervision. Mr Cormello remained in the care of the hospital.
34. On 4 March, the nurse (recorded as holding a Nurse Access Role) asked that the staff nurse on the ward record that Mr Cormello would not be suitable to return to Lewes, should he become fit for discharge.
35. On 8 March, the prison produced a special purpose licence granted on medical grounds and Mr Cormello was thereafter escorted by one officer. Prison healthcare staff maintained contact with hospital staff.
36. On 8 May, Mr Cormello was transferred to a Nursing Home where he remained until his death. Mr Cormello died on 18 May at 4.50am.

Contact with Cormello's family

37. On 1 February, the prison appointed a Senior Officer (SO) as the family liaison officer. The SO visited the named next of kin at his home to tell him that Mr Cormello was in hospital and had suffered from a suspected stroke. She said that although his condition was stable, he was not improving. She stayed in contact with the next of kin and kept him informed of Mr Cormello's condition and offered advice and support.
38. On 18 May, the SO informed the next of kin of Mr Cormello's death in person. Mr Cormello's funeral was held on 6 June 2018 and the SO, and two other prison managers attended. The prison contributed to the costs of the funeral in line with national policy.

Support for prisoners and staff

39. After Mr Cormello's death, the prison offered the escort officer who had accompanied Mr Cormello in hospital, support but there was no official debrief at the prison because Mr Cormello had been away from the prison on a special purpose licence.
40. The prison posted notices informing other prisoners of Mr Cormello'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 Cormello's death.

Post-mortem report

41. The coroner confirmed that Mr Cormello's cause of death was 1) pneumonia, and 2) cerebellar infarction and ischaemic heart disease.

Findings

Clinical care

42. We are satisfied that the care Mr Cormello received at HMP Lewes was equivalent to that which he could have expected to receive in the community.
43. Mr Cormello presented with a number of health issues which were complicated by his frailty and blindness. Staff had a good understanding of his conditions, and he was appropriately supported and referred for a social care assessment. Mr Cormello was admitted to hospital before the assessment could be completed but the continued communication between prison healthcare staff and hospital staff is to be commended.
44. Mr Cormello was granted a special purpose licence on medical grounds to facilitate the provision of appropriate, on-going medical care. Although he was escorted by a member of prison staff, restraints were not applied.
45. We make no recommendations.

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