Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Marco Del Becaro, a prisoner at HMP Swaleside, on 5 May 2021

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100
F I 020 7633 4141

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 Marco Del Becaro died on 5 May 2021 of epilepsy at HMP Swaleside. Mr Del Becaro was 52 years old. I offer my condolences to Mr Del Becaro's family and friends.

The clinical reviewer concluded that Mr Del Becaro's clinical care was not equivalent to that which he could have expected to receive in the community. Healthcare staff did not follow prison protocols or clinical guidance. There were shortfalls in the management of Mr Del Becaro's epilepsy, his non-compliance with treatment, record-keeping and the assessment of his mental capacity.

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 **March 2022**

Contents

Summary

Events

1. In September 2011, Mr Marco Del Becaro was given an indeterminate sentence for Public Protection (IPP) with a minimum tariff of eight years. Mr Del Becaro transferred to HMP Swaleside on 20 January 2015.

2. Mr Del Becaro had epilepsy. While at Swaleside he had frequent epileptic seizures and was often non-complaint with his anti-epileptic medication, claiming that taking the medication either caused or made his seizures worse. He was required to take his medication under supervision to help ensure his compliance. Doctors did not review his capacity to make decisions about his clinical care.

3. On 3 May 2021, an officer escorted a nurse to Mr Del Becaro's cell to give him his evening medication. The officer found untaken medication in his cell and gave it to healthcare staff. Mr Del Becaro again refused his medication that night. The nurse recorded in Mr Del Becaro's medical record that "he understood the implications of not taking the medication and displayed full capacity at time of conversation". The nurse's entry was written retrospectively on 7 May, four days after the incident, and after Mr Del Becaro's death.

4. At 8.40am on 5 May, a nurse went to give Mr Del Becaro his medication. He accepted the medication, but refused to drink his coffee, which was how he would normally swallow the tablets. The nurse did not check that Mr Del Becaro had swallowed his tablets before leaving the cell.

5. At 3.38pm, officers and a nurse found Mr Del Becaro lying on his cell floor face down. There were signs of rigor mortis, but the nurse started resuscitation while an officer called a code blue (indicating a life-threatening medical emergency) on his radio and asked for immediate medical assistance. Resuscitation attempts continued until the ambulance crew arrived at the prison at 4.06pm and a GP confirmed Mr Del Becaro's death at 4.10pm.

6. The post-mortem report concluded that Mr Del Becaro died from 'sudden unexpected death in epilepsy'.

Findings

Clinical care

7. The clinical reviewer concluded that Mr Del Becaro's clinical care was not equivalent to that which he could have expected to receive in the community. There were shortfalls in the management of his epilepsy, his non-compliance with treatment, record-keeping and the assessment of his mental capacity. The clinical reviewer found that healthcare staff did not follow healthcare protocols or clinical guidance.

Emergency response

8. Mr Del Becaro showed clear signs of rigor mortis when he was found in his cell on the afternoon of 5 May. Despite this, Nurse B and Officers A and B attempted

resuscitation, which was inappropriate and did not follow the healthcare provider's resuscitation policy.

Recommendations

- The Head of Healthcare should ensure that our report is shared with Nurse A and Nurse B, so they are aware of our findings.

- The Head of Healthcare should ensure that all clinical staff follow the required standards set out in national guidance and the healthcare provider's policies and protocols, particularly in relation to:

    - the management of epilepsy;
    - the management of non-compliance with treatment and medication;
    - supervised medication; and
    - record-keeping.

- The Head of Healthcare should ensure all healthcare staff are trained in the formal assessment of prisoners' mental capacity.

- The Governor and the Head of Healthcare should ensure that all staff are aware of the signs of rigor mortis; and fully understand the circumstances in which they should not start, or continue, resuscitation, in line with Resuscitation Council Guidelines.

- The Head of Healthcare should ensure that:

    - all staff are aware of the standard protocol around resuscitation; and
    - staff receive remedial training in resuscitation where necessary.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Swaleside informing them of the investigation and asking anyone with relevant information to contact her.

10. She obtained copies of relevant extracts from Mr Del Becaro's prison and medical records.

11. The investigator interviewed six members of staff at HMP Swaleside on 29 June, 1 and 27 July 2021. NHS England commissioned a clinical reviewer to review Mr Del Becaro's clinical care at the prison. The investigator and clinical reviewer jointly interviewed healthcare staff. All the interviews were conducted by telephone because of the COVID-19 restrictions.

12. We informed HM Coroner for Mid Kent and Medway of the investigation. She gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

13. One of the Ombudsman's family liaison officers contacted Mr Del Becaro's sister to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She asked for a copy of the report but did not have any questions for the investigation.

14. Mr Del Becaro's family received a copy of the draft report. They raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Swaleside

16. HMP Swaleside, on the Isle of Sheppey, is part of the Long-Term and High Security estate. It houses up to 1,112 men serving sentences of four years or more. Integrated Care 24 Ltd provides primary healthcare. There is 24-hour nursing cover and a 17-bed inpatient unit. GPs work in the prison Monday to Friday, and Medway on Call Care provides an out of hours GP service. Oxleas NHS Foundation Trust provides mental health services.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Swaleside was in December 2018. Inspectors reported that many of those held at Swaleside were high risk and presented a high risk of harm to others and it was unquestionably a difficult place to run. They found that health services had improved since their last inspection and were reasonably good, but a few areas were still concerning. The pressures of chronic staffing shortages had started to reduce. Prisoners could access an appropriate range of primary care services and visiting specialists. Waiting times for primary care services were reasonable but too many prisoners did not attend their appointments.

Independent Monitoring Board

18. 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 April 2020, the IMB found the general state of the prison to be far better than a year ago and highlighted the work undertaken by prison officers and governors, under very demanding circumstances (the COVID-19 pandemic) to safeguard vulnerable residents. These duties were carried out with the well-being of the individual as the clear priority.

19. They reported that while there was sometimes a long wait for GP appointments (up to three weeks), they were satisfied that residents' health and wellbeing needs were being met in line with standards in the outside community.

Previous deaths at HMP Swaleside

20. Mr Del Becaro was the eleventh person to die at HMP Swaleside since May 2019. Of these deaths, eight were from natural causes and three were drug-related. There have been three further deaths, two self-inflicted and one awaiting classification. There were no similarities between the findings in this case and our other investigations.

Key Events

21. Mr Marco Del Becaro was remanded into custody on 14 February 2011 for wounding with intent to do grievous bodily harm and sent to HMP Leicester. During an initial health screen, healthcare staff noted that he had epilepsy, and was blind in one eye after being shot by a crossbow. He had also been diagnosed with a personality disorder and had reduced mobility from a previous back injury (after a fall from an eight-storey building) and used elbow crutches.

22. On 8 September, Mr Del Becaro was given an Indeterminate sentence for Public Protection (IPP) with a minimum tariff of eight years. (Offenders sentenced to an IPP are set a minimum term which they must spend in prison. After they have completed their tariff, they can apply to the Parole Board for release.) Mr Del Becaro spent one year at HMP Elmley before transferring to HMP Swaleside on 20 January 2015.

HMP Swaleside

23. While at Swaleside, Mr Del Becaro had frequent epileptic seizures and was often non-complaint with his anti-epileptic medication. An epilepsy care plan was created on 1 August 2016, 18 months after his arrival at Swaleside.

24. Mr Del Becaro moved to the prison's healthcare centre on 9 June 2019, after being assaulted by another prisoner on the wing, so that healthcare staff could monitor a head injury. He refused to go back to the wing, and he stayed in the healthcare centre until 4 April 2020.

25. Mr Del Becaro continued to refuse to take his anti-epileptic medication for long periods. A prison GP and healthcare staff explained the importance of taking his medication and the associated risks of not taking it. Mr Del Becaro often claimed that taking the medication made his seizures worse.

26. In October 2019, Mr Del Becaro was found slumped on the floor of his cell following an epileptic seizure. He was taken to hospital, where he stayed until he was discharged back to Swaleside 23 days later. When he got back to the prison, healthcare staff continued to encourage Mr Del Becaro to take his medication.

27. On 19 March 2020, a prison GP saw Mr Del Becaro for a medication review. Mr Del Becaro explained that he felt well and often refused his medication "to help my legs". The GP encouraged him to take his medication and strongly advised against taking days off. He did not assess Mr Del Becaro's capacity to refuse his medication.

28. Mr Del Becaro moved from the prison's healthcare centre to G Wing on 4 April. Healthcare staff briefed officers about his increased risk of falls due to his reduced mobility and epilepsy, and he remained on supervised medication due to his non-compliance. This meant that he had to take his medication under the supervision of healthcare staff and that they had to be satisfied he had swallowed it.

29. Mr Del Becaro continued to have frequent epileptic seizures and on 29 October, healthcare staff went to the wing because he had had an epileptic fit that lasted

for 11 minutes. A nurse checked his heart rate and oxygen levels and recorded that he had tachycardia (fast heart rate) and low oxygen saturation, but Mr Del Becaro refused to go to hospital for observation. The wing's supervising officer agreed that officers would check Mr Del Becaro hourly and contact healthcare staff with any concerns.

30. On 15 December, a nurse booked a GP appointment for Mr Del Becaro on 8 January 2021, because he refused to take his medication. She noted that he had been non-compliant with his medication for some time and would benefit from a GP review.

31. On 20 January, a nurse noted that Mr Del Becaro had not attended his appointment with the GP on 8 January and said she would rebook it, although there is no record that she did so. Mr Del Becaro refused his medication again that evening, telling the nurse that he did not have epilepsy and he was worried that the anti-seizure medication was causing the condition.

32. On 3 May, an officer escorted Nurse A to Mr Del Becaro's cell to give him his evening medication. The officer made a note in Mr Del Becaro's prison record to say that, "Mr Del Becaro asked what they [his tablets] were and picked up a pot from his side cabinet, stating that he has been collecting them". The officer removed the pot containing two previously issued tablets. Mr Del Becaro refused to take his medication that evening.

33. Nurse A recorded in Mr Del Becaro's medical record that "he understood the implications of not taking the medication and displayed full capacity at time of conversation". Her entry was written retrospectively on 7 May, four days after this incident and after Mr Del Becaro's death.

5 May 2021

34. At 8.40am on 5 May, Nurse B went to Mr Del Becaro's cell to give him his medication. He accepted the medication, but refused to drink his coffee, which was how he would normally swallow the tablets. Despite Mr Del Becaro being on supervised medication, the nurse did not check that he had swallowed his tablets before leaving the cell.

35. An officer went to Mr Del Becaro's cell at 11.30am to ask him if he wanted any lunch. He did not want his lunch but took some bread to eat later on. The officer left the cell and locked Mr Del Becaro's door behind him. After lunch was served to all prisoners on the wing, CCTV footage shows the officer did a roll check, ensuring that all prisoners were locked in their cells. At 11.52am, he checked Mr Del Becaro's door observation panel. He said Mr Del Becaro was lying on the bed and "he responded with a thumbs up, which he did most days".

36. CCTV shows at 3.38pm Officer A, Officer B and Nurse B walked to Mr Del Becaro's cell to give him his evening medication.

37. Officer A opened the cell door and walked in with Nurse B and Officer B directly behind. Mr Del Becaro was lying on the floor face down. Officer A shook him to get a response. They turned him over but immediately noticed that his body was hard and rigid, and his face was a deep purple. Nurse B started resuscitation (chest compressions) while Officer B called a code blue (indicating a life-

threatening medical emergency) on his radio and asked for immediate medical assistance. He then shouted for other officers on the wing to help.

38. Nurse B continued with chest compressions while an officer collected a defibrillator from the wing office. When attached, the defibrillator confirmed that no shock was advised, and to continue with chest compressions. At this point the nurse became upset and left the cell.

39. Officers continued resuscitation attempts until more healthcare staff got to the cell at 3.47pm carrying another defibrillator, oxygen and healthcare's emergency bag. The ambulance crew arrived at the prison at 4.06pm and a GP confirmed Mr Del Becaro's death at 4.10pm.

Contact with Mr Del Becaro's family

40. A Custodial Manager (CM) spoke to Mr Del Becaro's sister at 5.54pm the same day to break the news of her brother's death. He offered support and answered her questions. The CM kept in regular contact and the prison offered to contribute to the cost of Mr Del Becaro's funeral, in line with national instructions.

Support for prisoners and staff

41. After Mr Del Becaro's death, prison managers 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.

42. The prison posted notices informing other prisoners of Mr Del Becaro'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 Del Becaro's death.

Post-mortem report

43. The post-mortem report concluded that Mr Del Becaro died from 'sudden unexpected death in epilepsy'.

Findings

Clinical care

44. The clinical reviewer concluded that Mr Del Becaro's clinical care was not equivalent to that which he could have expected to receive in the community. There were shortfalls in the management of his epilepsy, his non-compliance with treatment, record-keeping and the assessment of his mental capacity. Healthcare staff did not follow all relevant national guidelines or the healthcare provider's own policies.

Management of epilepsy

45. Mr Del Becaro suffered frequent epileptic seizures and often refused to take medication to manage his seizures for long periods of time. Despite this, an epilepsy care plan was not put in place until 18 months after he arrived Swaleside. His last recorded GP appointment took place in March 2020, more than a year before he died.

46. The Head of Healthcare told the investigator that if a prisoner refuses to take medication five times in a row, it should prompt a GP review in line with the healthcare provider's Medication Refusal Protocol. The clinical reviewer confirmed that healthcare staff sometimes made GP appointments when Mr Del Becaro refused his medication, but not on every occasion that met this threshold. The protocol also requires that an appointment should be arranged sooner if the medication is critical. The clinical reviewer considered that Mr Del Becaro's medication was critical to managing his epilepsy, so GP appointments should have been made more frequently and with more urgency.

47. Mr Del Becaro often did not go to medical appointments. The healthcare provider's protocol requires that healthcare staff should visit patients who have failed to attend two consecutive appointments to understand why and encourage them to go to the next appointment. There is no evidence that anyone visited Mr Del Becaro to discuss this with him, contrary to the protocol.

48. To manage the risk of Mr Del Becaro not taking his medication, healthcare staff arranged to supervise him each time he took his medication. Despite this, Nurse A found extra medication in his cell on the evening of 3 May 2021. She did not record this discovery until after Mr Del Becaro's death, contrary to national guidelines. Nurse B told the investigator that he did not check Mr Del Becaro had taken his medication before he left the cell on the morning of 5 May 2021. We share the clinical reviewer's concerns that the arrangements to supervise Mr Del Becaro's medication were not sufficiently robust.

49. The clinical reviewer concluded that Mr Del Becaro's care fell below the required standard and was therefore not equivalent to that he could have expected to receive in the wider community. We make the following recommendations:

The Head of Healthcare should ensure that all clinical staff follow the required standards set out in national guidance and the healthcare provider's policies and protocols, particularly in relation to:

- **the management of epilepsy;**
- **the management of non-compliance with treatment and medication;**
- **supervised medication; and**
- **record-keeping.**

The Head of Healthcare should ensure that our report is shared with Nurse A and Nurse B, so they are aware of our findings.

Mental Capacity

50. Mr Del Becaro was frequently non-compliant with his anti-epileptic medication. It is noted in his medical record on several occasions that he had full mental capacity to make decisions. However, the clinical reviewer found no evidence that healthcare staff formally assessed his mental capacity to inform this judgement.

51. The Head of Healthcare confirmed that SystmOne (the electronic medical record) contains a template to formally assess mental capacity of an individual. Three healthcare staff all said in interview that they did not know about the formal capacity template. A prison GP said he would rely on his clinical judgement rather than use a template.

52. Mr Del Becaro's decisions not to engage with treatment or take his medication were not in line with medical advice. We agree with the clinical reviewer that his mental capacity to make those decisions should have been formally assessed and we make the following recommendation:

The Head of Healthcare should ensure all healthcare staff are trained in the formal assessment of prisoners' mental capacity.

Emergency response

53. Mr Del Becaro was found unresponsive on his cell floor at 3.38pm on 5 May 2021. Nurse B immediately started resuscitation attempts. In his prison statement, he confirmed that Mr Del Becaro's lips were blue and his arms stiff.

54. Officer A said at interview that, Mr Del Becaro was "rock hard, rigor mortis was there" and he "immediately thought he was dead" but he still decided to attempt resuscitation. Officer B, who assisted with the resuscitation, also thought Mr Del Becaro had died. However, he explained that he had been taught as part of his first aid training that you "continue CPR regardless" even if you think someone has died.

55. The healthcare provider's resuscitation policy states that it is based on the Quality Standards for Clinical Practice and Training in Cardiopulmonary Resuscitation published by the Resuscitation Council (RC UK) - updated in 2020. The Resuscitation Council guidance says, "There will be some people for whom attempting CPR is clearly inappropriate; for example…. there will be cases where healthcare professionals discover patients with features of irreversible death, for example, rigor mortis". Mr Del Becaro showed clear signs of rigor

mortis and the clinical reviewer concluded that resuscitation would have been futile.

56. Officer A confirmed at interview that he is a first aid instructor. It is concerning that while both officers thought Mr Del Becaro had died, they still carried out resuscitation. Nurse B joined their efforts.

57. We make the following recommendation:

The Governor and the Head of Healthcare should ensure that all healthcare staff are aware of the signs of rigor mortis; and fully understand the circumstances in which they should not start, or continue resuscitation, in line with Resuscitation Council Guidelines.

58. The clinical reviewer was concerned that Nurse B left the cell while resuscitation was taking place because he became upset, even though he was the only clinically trained person present, and CCTV shows that other healthcare staff did not arrive for another four minutes. The nurse said at interview that he was asked to leave the cell by the prison officers, who then prevented him from returning. This is contradicted by CCTV evidence and the statements of the officers.

59. The clinical reviewer recognised that discovering a patient to be unresponsive and carrying out resuscitation and life support can be extremely stressful and upsetting, particularly when an individual is known to the clinical staff. However, training as a clinician should emphasise the importance of coping with this stress and upset at the time and continuing to carry out a co-ordinated resuscitation process according to standard protocols until other clinicians or paramedics can take over.

60. However, the clinical reviewer concluded that as resuscitation would in fact have been futile in this case, Nurse B's behaviour did not contribute to Mr Del Becaro's death.

61. We recommend:

The Head of Healthcare should ensure that:

- **all staff are aware of the standard protocol around resuscitation; and**
- **any remedial training in resuscitation processes takes place.**

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100
F I 020 7633 4141