

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Michael Meanza, a prisoner at HMP Gartree, on 29 January 2021

**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 we oversee can improve their work in the future.

Mr Michael Meanza died on 29 January 2021, of sudden unexpected death in epilepsy, at HMP Gartree. Mr Meanza was 52 years old. I offer my condolences to Mr Meanza's family and friends.

The clinical reviewer concluded that the epilepsy and mental health care that Mr Meanza received at Gartree was not equivalent to that which he could have expected to receive in the community.

She was particularly concerned that Mr Meanza did not have a review of his epilepsy care plan in 2020, in line with NICE guidelines, and that his epilepsy care plan review in 2019 was carried out by a nurse with no specialist training in epilepsy.

The clinical reviewer considered that it would have been difficult for staff to have successfully intervened to save Mr Meanza given the nature of sudden unexpected death in epilepsy.

I am concerned that welfare checks were not carried out in line with policy and there were significant delays in identifying that Mr Meanza was not well or that he had died.

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**

**April 2022**

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# Summary

## Events

1. On 2 March 2016, Mr Michael Meanza was sentenced to life imprisonment for murder and received a minimum tariff of 26 years.
2. Mr Meanza had several pre-existing health conditions including, chronic paranoid schizophrenia, dissocial personality disorder, epilepsy and congenital hypothyroidism. He received a range of medication for his epilepsy and schizophrenia.
3. On 31 October 2019, Mr Meanza transferred to HMP Gartree.
4. In January 2021, there were several incidents where Mr Meanza's behaviour was unusual or of concern. He told another prisoner that he was going to harm himself. He was seen to urinate on the floor of his wing and there were concerns that he was abusing the Samaritans Listener service. When prison staff challenged him about his anti-social use of his radio through the night, he was verbally abusive.
5. Just before 11.00am on 29 January, prison staff found Mr Meanza unresponsive in his cell. He was not breathing and cold to the touch. Staff called a medical emergency code. The prison control room called an emergency ambulance.
6. Healthcare staff attended Mr Meanza's cell. They assessed that CPR would not be appropriate and that Mr Meanza had been dead for some time.
7. At 11.24am, paramedics confirmed that Mr Meanza had died.

## Findings

8. The clinical reviewer concluded that the care Mr Meanza received at Gartree was not equivalent to that which he could have expected to receive in the community. She was concerned about his epilepsy care, the lack of physical health reviews for his anti-psychotic medication and the poor quality of record keeping relating to his mental health care.
9. We are concerned that prison staff failed to conduct proper welfare checks on 29 January.

## Recommendations

- **The Head of Healthcare should ensure that prisoners suffering from epilepsy have a review of their condition at least yearly, by a suitably trained doctor or specialist nurse, in line with NICE guidelines.**
- **The Head of Healthcare should ensure there is a robust process in place for reviewing the recording of mental health consultations in the SystemOne records to ensure their accuracy and completeness.**
- **The Head of Healthcare should ensure that systems are in place to monitor the physical health of prisoners taking anti-psychotic medication and**

**ensure that prisoners are offered yearly checks of blood and physical health in line with NICE guidelines.**

- **The Governor should ensure that staff satisfy themselves of the wellbeing of all prisoners during the morning unlock.**

## The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Gartree informing them of the investigation and asking anyone with relevant information to contact him. A prisoner contacted the investigator.
11. The investigator wrote to the prison on 1 February 2021. He obtained copies of relevant extracts from Mr Meanza's prison and medical records.
12. NHS England commissioned a clinical reviewer to review Mr Meanza's clinical care at the prison.
13. The investigation was suspended between 29 January and 12 July 2021, while the post-mortem and toxicology reports were completed.
14. The investigator and clinical reviewer interviewed three members of staff by telephone on 19 and 20 August. The investigator interviewed two members of staff by telephone on 24 September. He interviewed a prisoner by telephone on 15 October.
15. We informed HM Coroner for Leicester City & South Leicestershire of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
16. The Ombudsman's family liaison officer contacted Mr Meanza's parents to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They asked for a copy of this report, which has been sent to them.
17. Mr Meanza's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.
18. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies. The PPO and the Prison Service agreed to amend the wording of one recommendation, which did not change the substance of that recommendation.

## Background Information

### HMP Gartree

19. HMP Gartree is a medium security prison located outside Market Harborough in Leicestershire. It has capacity to hold 708 men and is predominantly for prisoners serving life or other indeterminate sentences.
20. HMP Gartree has 24-hour healthcare services provided by Nottinghamshire Healthcare Foundation Trust. Their services cover physical health, mental health and substance misuse.

### HM Inspectorate of Prisons

21. The most recent full inspection of HMP Gartree was in November 2017. Inspectors reported that healthcare provision had deteriorated. The service was suffering from serious nursing staff shortages and a high reliance on agency staff. Owing to staff shortages, long-term conditions were managed by the GP. Not all patients with long-term conditions had been identified and care plans were not always in place to manage chronic conditions such as diabetes and asthma. Inspectors noted that a new healthcare provider had recently taken over and there was a reasonable expectation that matters would improve.
22. In September 2020, HMIP conducted a scrutiny visit (a shortened inspection due to COVID-19) at Gartree. Inspectors reported that healthcare services had improved since their last visit, particularly in the care of patients with long-term conditions. Healthcare services were well led and most of the previous recommendations had been addressed.

### Independent Monitoring Board

23. 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 1 December 2019 to 30 November 2020, the IMB had concerns about the support available for prisoners with complex mental health needs.

### Previous deaths at HMP Gartree

24. Mr Meanza was the eighth prisoner to die at HMP Gartree since January 2019. Of the previous deaths, six were from natural causes and one was self-inflicted.
25. In a previous investigation into the death of a prisoner in 2019, we raised concerns about the lack of personalised care plans being created. We recommended that this should be done in line with NICE guidelines.
26. The prison accepted our recommendation and said that they had recruited a specialist nurse to lead on complex care and had recruited a matron to oversee staff training.

## Key Events

27. In July 2015, Mr Michael Meanza was remanded to HMP Wormwood Scrubs, charged with murder. On 2 March 2016, he was sentenced to life imprisonment with a tariff of 26 years. On 23 March 2017, his tariff was reduced on appeal to 21 years.
28. Mr Meanza had a number of pre-existing health conditions, including, chronic paranoid schizophrenia, dissocial personality disorder, epilepsy and congenital hypothyroidism. He received a range of medication, including sodium valproate for his epilepsy and olanzapine for his schizophrenia.
29. In July 2016, at his secondary health screening, Mr Meanza told a prison GP that his last epileptic fit had been two years before. He told the GP that he suffered from partial and tonic-clonic seizures.

### 2019

30. On 31 October 2019, Mr Meanza transferred to HMP Gartree.
31. On arrival at Gartree, Mr Meanza had a health screening. Healthcare staff noted his epilepsy and prescribed medication. They referred him to the prison's mental health team.
32. In November, a nurse saw Mr Meanza. He completed a mental health care plan and referred him to the substance misuse team because Mr Meanza said that he had bought illicit substances at his previous prison.
33. On 18 November, a nurse created an epilepsy care plan for Mr Meanza and, on 25 November, she completed a review of his epilepsy. Mr Meanza told the nurse that his last epileptic fit had been two years before. The same day, a substance misuse worker also saw Mr Meanza.
34. Over the following months, the substance misuse worker and Mr Meanza met regularly and discussed his substance misuse, including psychoactive substance (PS) known as 'spice', alcohol, benzodiazepines and cannabis.
35. On 10 December, Mr Meanza's mental health care was allocated to another mental health nurse.
36. Staff suspected that Mr Meanza was trying to divert his medication. On 17 December, staff saw him put his medication in his pocket and walk away. They challenged him and reminded him to take his medication as directed.

### 2020

37. During the months that followed, there were a number of incidents where Mr Meanza behaved in an anti-social manner towards staff and other prisoners, including playing his radio loudly through the night, misusing the Listener service (from which he was, at times, then banned) and allegedly showing other prisoners crime scene photographs from the murder. It is unclear why he would have been in possession of such material.

38. On 7 January 2020, the mental health nurse saw Mr Meanza. They discussed his recent use of 'Spice'. Mr Meanza said that it was a one-off incident.
39. On 25 January, prison staff radioed a 'code blue' (a medical emergency code used when a prisoner is unconscious or having breathing difficulties). They suspected that Mr Meanza was intoxicated from using 'Spice'. Healthcare staff assessed him, and he did not need hospital treatment.
40. In March, the mental health nurse saw Mr Meanza. He told the nurse that he sometimes forgot to take his evening medication. Earlier that day, a Multi-Disciplinary Team (MDT) meeting had discussed that Mr Meanza had not taken his sodium valproate and olanzapine for five days (although this meeting was not recorded in his medical notes).
41. In April, a prison GP asked healthcare staff to complete an in-possession medication risk assessment for Mr Meanza. On 26 April, the mental health nurse completed the assessment. Mr Meanza began receiving weekly in-possession medication from May.
42. In May, a nurse reviewed Mr Meanza's epilepsy care plan without a consultation with him. A follow-up review for his epilepsy was listed for 20 November. There is no evidence that this review took place.
43. On 5 June, an audit of his in-possession medication showed that there were three olanzapine tablets missing. Mr Meanza told staff he had not been given enough tablets. Olanzapine was removed from his in-possession medication.
44. In June, a prisoner was asked to support Mr Meanza. The prisoner was appointed as a residential support assistant (RSA – also known as a 'buddy') to help Mr Meanza with his laundry and cleaning. He helped Mr Meanza by reminding him to wash, change his clothes, clean his cell and other administrative tasks such as ordering meals.
45. By mid-October, Mr Meanza's personal hygiene had deteriorated and on 16 October, prison staff had to have his cell biologically cleaned.
46. Throughout his time at Gartree, Mr Meanza was noted by staff to be preoccupied with a non-contact order that prevented him from contacting his former girlfriend. At times, this dominated his conversations with prison and healthcare staff. Mr Meanza consistently refused to accept that his former girlfriend did not wish contact with him. On more than one occasion he sought to challenge this order.

## **2021**

47. On 4 January 2021, Mr Meanza wrote to the prison IMB complaining about the non-contact order.
48. On 5 January, the buddy told prison staff that on the previous evening, Mr Meanza told him that he would "top himself". When prison staff spoke to Mr Meanza, he denied any intention to harm himself. Prison staff contacted the mental health team. There is no evidence this information was reviewed by the mental health team or followed up with Mr Meanza.

49. On 9 January, while the buddy was helping Mr Meanza and another prisoner complete their meal orders, Mr Meanza wet himself. The buddy helped Mr Meanza get cleaned up and asked him why this had happened. Mr Meanza said that he knew he could not get to the toilet in time, so went where he stood. The buddy reported this to prison staff. Prison staff referred Mr Meanza to the prison's healthcare unit.
50. On 17 January, the chair of the IMB sent Mr Meanza a reply to his complaint. He advised this was not something the IMB could help Mr Meanza with.
51. That day, a member of prison staff recorded that there had been numerous complaints from other prisoners that Mr Meanza had been playing music loudly through the night. When the staff member advised him to keep his music down, Mr Meanza responded by shouting at her.
52. On 21 January, an MDT met to discuss Mr Meanza's incontinence. A prison GP ordered a mental health review and a urine test to examine any drug and medication use or signs of infection.
53. On 24 January, the mental health nurse saw Mr Meanza. They discussed his incontinence. Mr Meanza denied he had any continence issues and said he could not understand why prison staff had said this had happened. The prison healthcare team held a complex care meeting on 28 January and discussed Mr Meanza. Mr Meanza had refused to provide a urine sample.
54. At around 8.00pm, the night Operational Support Grade (OSG) came on duty. He received a verbal handover from an officer who then went off duty. He then completed a roll check. In his statement, he said that he had no interaction with Mr Meanza during the night of 28 and 29 January. It is not clear when Mr Meanza was last seen alive.

### **Events of 29 January 2021**

55. At around 5.10am, the OSG completed a roll check of C wing. When he looked through the observation panel of Mr Meanza's cell door, he saw Mr Meanza lying on his bed and he appeared to be asleep.
56. At around 7.10am, a prison officer came onto C wing to relieve the OSG. They had a verbal handover during which he told her there was nothing to report.
57. At around 7.15am, the prison officer carried out roll checks on the wing. She opened the observation panel of Mr Meanza's cell and shone her torch into the cell. She saw Mr Meanza lying on his side, facing the wall. She thought she saw him move. She checked his door was locked and moved on with the roll check.
58. Sometime between 9.00am and 9.30am, another prison officer unlocked Mr Meanza's cell and stepped into the doorway of the cell. He offered Mr Meanza a shower. He got no reply. He saw Mr Meanza lying on his side facing the wall. He noted that Mr Meanza appeared to be asleep fully clothed in his bed, so he left and locked the cell door.

59. At around 10.55am, the same prison officer unlocked Mr Meanza's cell. He called out to Mr Meanza. When he got no response, he went to rouse Mr Meanza who was in the same position in bed.
60. He placed his hand on Mr Meanza's shoulder and found he was cold to the touch. He then placed his hand in front of Mr Meanza's mouth but could not feel any breath. He felt for a pulse on his wrist but could not find one. Two other officers attended Mr Meanza's cell.
61. At 10.58am, an officer called a 'code blue'. The prison control room called an ambulance at 11.02am.
62. Healthcare staff arrived at Mr Meanza's cell at 11.06am. They found Mr Meanza was cold to the touch, his jaw was fixed, and his body was stiff. They assessed that he had been dead for some time and that CPR would not be appropriate.
63. At 11.13am, an emergency ambulance arrived at Gartree. Paramedics noted that there were no signs of life and rigor mortis had set in. They noted what appeared to be blood around Mr Meanza's mouth and nose. They recorded his death at 11.24am.
64. During the emergency response when moving Mr Meanza, staff found a note near his mouth. The note said, "I can't do this anymore...it's the feeling that I've lost her love. See you on the other side darling". Staff also found Mr Meanza's medication dosette box which was empty. Mr Meanza was due a refill of his in-possession medication that day.

### **Contact with Mr Meanza's family**

65. Following Mr Meanza's death, the prison appointed a family liaison officer (FLO). At 12.50pm, the FLO rang Mr Meanza's next of kin, his parents, to inform them that Mr Meanza had died. The FLO offered her condolences and over the following days provided support and information to Mr Meanza's parents.
66. Mr Meanza's funeral was held on 24 February 2021. In line with policy, the prison made a financial contribution to the cost of the funeral.

### **Support for prisoners and staff**

67. After Mr Meanza's death, an operational manager 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.
68. The prison posted notices informing other prisoners of Mr Meanza'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 Meanza's death.

### **Post-mortem report**

69. The pathologist concluded that Mr Meanza's cause of death was sudden unexpected death in epilepsy (SUDEP). The post-mortem found no evidence of any non-natural cause (drug or alcohol toxicity, suicide or homicide) of death.

70. The toxicology report found that there was no trace of either sodium valproate (his anti-epilepsy medication) or olanzapine (his anti-psychotic medication) in Mr Meanza's blood. The clinical reviewer considered that this meant that Mr Meanza was not taking either medication at the time of his death. She assessed it was likely he had not been compliant with his medication for at least a number of days.

# Findings

## Clinical Findings

71. The clinical reviewer concluded that while elements of his care were equivalent to that which he could have expected to receive in the community, the epilepsy and mental health care that Mr Meanza received at Gartree was not equivalent to that which he could have expected to receive in the community.
72. She was concerned about his epilepsy care, the lack of physical health reviews for his anti-psychotic medication and the poor quality of record keeping relating to his mental health care.

## Epilepsy care

73. Mr Meanza had epilepsy for which he was prescribed sodium valproate. This was appropriate medication for the treatment of the tonic-clonic seizures that he said he suffered from. However, she found that there was no evidence of any witnessed seizures in his medical or prison record. When healthcare staff asked Mr Meanza about his seizures, he said that he had not had a fit for a number of years.
74. The clinical reviewer was concerned about Mr Meanza's epilepsy care. He did not have an epilepsy review at his previous prison, HMP Belmarsh. On arrival at Gartree he was allocated to a nurse. She had responsibility for all prisoners with long-term health conditions. In interview, she said that she did not have any training in epilepsy.
75. NICE guideline CG137 says that adults with epilepsy should be reviewed by a GP or specialist nurse at least yearly. Mr Meanza did not have any further epilepsy checks after November 2019. At interview, the Head of Healthcare said that this was a failure of the recall system.
76. The post-mortem toxicology report did not find any trace of sodium valproate in Mr Meanza's blood. This shows that Mr Meanza had not taken any of his epilepsy medication for at least a few days before his death. On 29 January, when staff found Mr Meanza in his cell, they also found an empty dosette box. It is not known what he did with his medication.
77. Mr Meanza's compliance with medication had been an issue in 2020. In March, he admitted forgetting to take his medication. In June, an audit of his medication had found missing tablets. His anti-psychotic medication was removed from his in-possession list.
78. In interview, the Head of Healthcare told us that in-possession medication audits were significantly reduced to mitigate against spreading COVID-19 within the prison, which had experienced COVID-19 outbreaks in October and November 2020. This meant that in January 2021, Mr Meanza's compliance with his epilepsy (and anti-psychotic medication) was not audited.
79. We make the following recommendation:

**The Head of Healthcare should ensure that prisoners suffering from epilepsy have a review of their condition at least once a year by a suitably trained doctor or specialist nurse, in line with NICE guidelines.**

### **Mental health care**

80. Mr Meanza had chronic paranoid schizophrenia. He also had dissociative personality disorder. Prior to his prison sentence, he had been admitted to psychiatric hospitals several times.
81. While at Gartree, Mr Meanza was allocated to the caseload of a mental health nurse. He reviewed Mr Meanza every 2 to 4 weeks. From June 2020 until Mr Meanza's death, the nurse also provided substance misuse care. At interview, the nurse said that he had a good relationship with Mr Meanza who he considered to be trustworthy.
82. The clinical reviewer found that, at times, the nurse did not challenge or explore Mr Meanza's use of illicit substances in 2020, and his incontinence in 2021.
83. At post-mortem, toxicology analysis found no trace of olanzapine in Mr Meanza's blood. At interview, the nurse said that Mr Meanza was always adamant that he was taking his medication, had no side effects and felt that it was doing him good. However, in March 2020, Mr Meanza admitted that he had not been taking medication for a number of days. In June 2020, his olanzapine medication was taken out of his possession when three tablets were found to be missing. The nurse also said that on occasion he completed spot checks on Mr Meanza's supply of medication and had no cause for concern. These checks were not recorded in Mr Meanza's medical records.
84. The clinical reviewer was concerned about the quality of the nurse's record keeping. She found his entries in Mr Meanza's medical records were very repetitive, to the extent of recording the same results of a physical health check on two separate dates. The nurse said that this was due to a computer glitch. Given the large number of such repeat entries on many occasions, the clinical reviewer found that this explanation lacked plausibility.
85. The clinical reviewer reviewed the January 2021 entries in his medical and prison records, which noted unusual behaviour. She considered that these behaviours suggested that Mr Meanza may have stopped taking his anti-psychotic medication in early January 2021. We recommend:

**The Head of Healthcare should ensure there is a robust process in place for reviewing the recording of mental health consultations in the SystmOne records to ensure their accuracy and completeness.**

### **Physical health reviews**

86. NICE guidelines require that prisoners taking anti-psychotic medication should have an annual review of their physical health. The clinical reviewer found that during his time at Gartree the yearly reviews had not taken place. We recommend:

**The Head of Healthcare should ensure that systems are in place to monitor the physical health of prisoners taking anti-psychotic medication and ensure that prisoners are offered yearly checks of blood and physical health in line with NICE guidelines.**

## **Non-Clinical Findings**

### **Unlock procedures and wellbeing checks**

87. Prison Service Instruction (PSI) 75/2011, *Residential Services*, says:

*“Reports from the Prisons and Probation Ombudsman on deaths in custody have identified cases in which a prisoner has died overnight, apparently from natural causes, but staff unlocking them have not noticed that the prisoner had died. This is not acceptable. The specification requires there to be positive engagement between staff and prisoners and for prisoners to be supported and their daily needs met, and this clearly requires some form of interaction or conversation to take place at times during the day”.*

And:

*“Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process.”*

88. Mr Meanza was found unresponsive in his cell shortly before 11.00am. The prison officer who found Mr Meanza said that he was cold to the touch and not breathing. The nurses assessed that CPR was not appropriate and that Mr Meanza had been dead for some time.

89. There had been two checks on Mr Meanza earlier that morning: one at around 7.15am and one at around 9.30am. During both checks, the staff assessed that Mr Meanza was asleep and appeared well.

90. The officers who carried out those checks both said that they could not remember if Mr Meanza’s radio was on loudly – although they reported that Mr Meanza often had his radio on loudly through the night. In their prison statements they wrote that Mr Meanza’s radio was on loudly. Both staff told us that Mr Meanza often slept in the same position, with his back to the cell door and his head at the door end of the cell. One of the officers also told us that Mr Meanza was a heavy sleeper and difficult to wake.

91. We consider that Mr Meanza’s sleeping position and his use of his radio made it harder for staff to accurately determine if he was alive. However, it was the responsibility of prison staff to assure themselves that he was well and did not require assistance and intervention.

92. More widely we note that Mr Meanza’s repeated use of his radio through the night caused irritation to other prisoners, was anti-social and was similar to behaviour he showed in the run up to the murder he committed. We note that there appeared to be periodic challenge to Mr Meanza’s use of his radio – including turning off the electrics in his cell. However, this was inconsistent. This

lack of consistency normalised his anti-social use of his radio at night, which in turn made it harder for staff to carry out welfare checks.

93. We accept that it may not be appropriate for staff to get a response from prisoners during a morning roll check. However, PSI 75/2011 is clear that staff are expected to check prisoners' wellbeing by getting a response at unlock, including checking on prisoners who are not leaving their cell.
94. We cannot say if the outcome would have been different for Mr Meanza if he had been found earlier, but a failure to check on a prisoner's wellbeing at unlock could make a critical difference in other cases. We make the following recommendation:

**The Governor should ensure that staff satisfy themselves of the wellbeing of all prisoners during the morning unlock.**

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