Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Anthony Bullett, a prisoner at HMP/YOI Norwich, on 9 November 2025

A report by the Prisons and Probation Ombudsman

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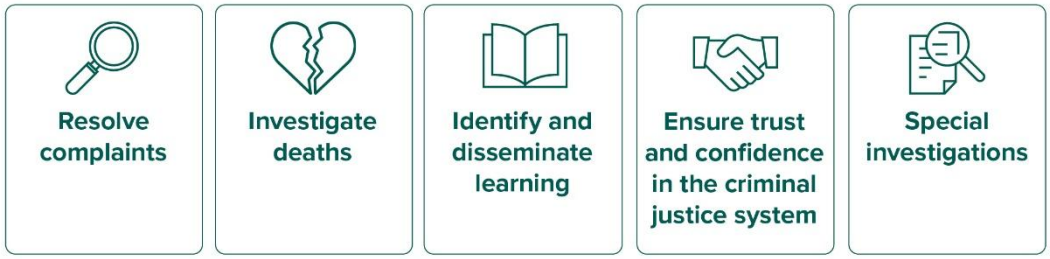
OUR VISION

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

WHAT WE DO



WHAT WE VALUE

1. 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.

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

3. On 9 October 2024, Mr Anthony Bullett was sentenced to 16 months in prison for breaching a sexual harm prevention order. On 14 August 2025, he was released from prison but was recalled to prison on 20 August for further breaches. He died of multiorgan failure caused by rapid cognitive impairment on 9 November 2025, at HMP Norwich. He was 77 years old. We offer our condolences to Mr Bullett's family and friends.

4. The Ombudsman's office wrote to Mr Bullett's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They had no questions but asked for a copy of our report.

5. NHS England commissioned an independent clinical reviewer to review Mr Bullett's clinical care at HMP Norwich. The clinical reviewer's report is attached as Annex 1.

6. The clinical reviewer concluded that the clinical care Mr Bullett received at Norwich was of a good standard and equivalent to what he could have expected to receive in the community. She found that appropriate care plans were in place to support his health, including an individual end-of-life care plan, and that Mr Bullett received compassionate and dignified end-of-life care. The clinical reviewer made recommendations not related to Mr Bullett's death that the Head of Healthcare will wish to address.

7. The PPO investigator investigated the non-clinical issues relating to Mr Bullett's care.

8. We did not find any non-clinical issues of concern. We make no recommendations.

9. The initial report was shared with HM Prison and Probation Service (HMPPS). Health Care Resourcing Group (HCRG) raised a factual inaccuracy in the clinical review. The investigator passed these on to the clinical reviewer who amended their report which is annexed to this report.

10. We also shared the initial report with Mr Bullett's family. They did not make any comments.

Adrian Usher
Prisons and Probation Ombudsman **June 2026**

Inquest

At the inquest held on 17 July 2026, the Coroner concluded that Mr Bullett died of natural causes.

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