

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Charles Eaton a prisoner at HMP Norwich on 5 May 2020

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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Summary

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. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Charles Eaton died on 5 May 2020 of heart failure at HMP Norwich. He was 89 years old. We offer our condolences to Mr Eaton's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Eaton received at Norwich was equivalent to that he could have expected to receive in the community. She made two recommendations but as they do not relate directly to Mr Eaton's death, we do not repeat them in this report.
5. A prison nurse told Mr Eaton's family of his death. This was not in line with prison policy as a family liaison officer should do this. However, we are satisfied that the prison identified this issue and took appropriate action, so we have not made a recommendation.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Eaton's clinical care at Norwich.
7. The PPO investigator has investigated non-clinical issues, including Mr Eaton's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. One of the PPO's family liaison officers wrote to Mr Eaton's next of kin to explain the investigation. He did not respond.
9. The initial report was shared with the HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at HMP Norwich

10. Mr Eaton was the ninth prisoner to die at Norwich since May 2018. Of the previous deaths, six were from natural causes and two were self-inflicted. There are no similarities between our findings in the investigation into Mr Eaton's death and our investigation findings for the previous deaths.

Key Events

11. On 3 August 2018, Mr Charles Eaton was sentenced to 10 years in prison for sexual offences. He was taken to HMP Norwich.
12. Mr Eaton had multiple long-term medical conditions including chronic obstructive pulmonary disease (COPD – the term for a group of lung diseases including chronic bronchitis and emphysema), heart disease and diabetes. When he arrived at Norwich, his life expectancy was about a year. He had already signed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order, which said that if he stopped breathing, he did not want to be resuscitated.
13. Mr Eaton was located on the healthcare wing for sick, elderly and vulnerable prisoners. He received palliative care from October 2019.
14. In September 2019, and again in March 2020, staff started an application for Mr Eaton’s early release on compassionate grounds but, due to an improvement in his condition, neither application received medical support. Staff started a third application in May 2020, but Mr Eaton died before its completion.
15. Mr Eaton died in his cell on 5 May. There was no post-mortem examination as the Coroner accepted the cause of death provided by a doctor. The doctor gave the cause of death as severe congestive cardiac failure (heart failure).
16. After Mr Eaton’s death, a prison nurse contacted Mr Eaton’s family to inform them of his death. This breach of protocol (the prison family liaison officer or a prison manager would normally tell the family) was identified by the prison and the healthcare provider held an internal investigation. They concluded that the nurse had a good relationship with Mr Eaton’s family and had acted in good faith. No further action was taken against her, but they have since provided guidance to all staff reminding them of the procedures to follow under similar circumstances. We are satisfied that the action taken by the prison and the healthcare provider was appropriate.

Louise Richards
Assistant Ombudsman

October 2020

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