

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

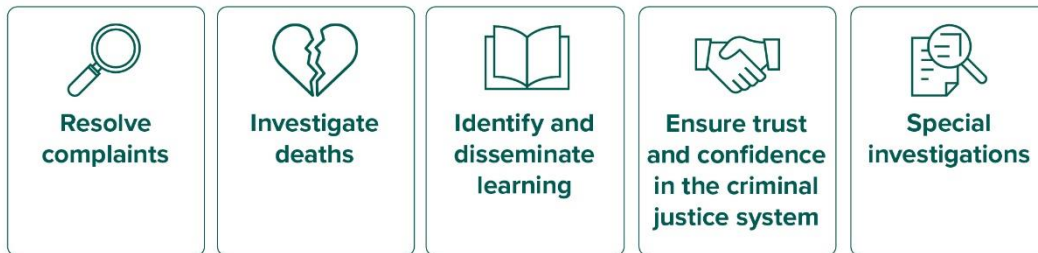
# **Independent investigation into the death of Mr Percy Mouncer, a prisoner at HMP Norwich, on 4 April 2023**

**A report by the Prisons and Probation Ombudsman**

## 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



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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. 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. Mr Percy Mouncer died of prostate cancer at HMP Norwich on 4 April 2023. He was 76 years old. We offer our condolences to Mr Mouncer's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Mouncer received at Norwich was equivalent to that which he could have expected to receive in the community. The clinical reviewer made recommendations about putting processes in place so that prison healthcare staff could verify expected deaths, rather than using ambulance staff to do so. We do not repeat them here, but the Head of Healthcare will wish to address them.
5. We found no non-clinical issues of concern. We make no recommendations.

## The Investigation Process

6. HMPPS notified us of Mr Mouncer's death on 4 April 2023.
7. NHS England commissioned an independent clinical reviewer to review Mr Mouncer's clinical care at Norwich.
8. The PPO investigator investigated the non-clinical issues relating to Mr Mouncer's care.
9. The PPO family liaison officer wrote to Mr Mouncer's nominated next of kin, a friend, to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.
10. We shared our initial report with HMPPS. They found no factual inaccuracies.

## Previous deaths at HMP Norwich

11. Mr Mouncer was the 13<sup>th</sup> prisoner at Norwich to die since April 2020. Of the previous deaths, nine were from natural causes and three were self-inflicted.
12. We have previously made a recommendation about healthcare staff at Norwich verifying death to minimise the use of emergency services. In June 2022, we were told that the GP would verify death if they were on shift and if not, then healthcare staff would call 111 who would supply a GP to verify death.

## Key Events

13. Mr Percy Mouncer was remanded to prison in 2014 charged with sexual offences. He was subsequently sentenced to 16 years imprisonment.
14. In early 2019, Mr Mouncer was diagnosed with prostate cancer. He had radiotherapy treatment.
15. In October 2022, Mr Mouncer was diagnosed with a metastatic brain tumour caused by the spread of his cancer. Doctors told him that his life expectancy was weeks to months.
16. On 14 October, Mr Mouncer was moved to HMP Norwich and located on L Wing, a specialist wing providing social and palliative care. Mr Mouncer's medical record showed that he had previously signed an order to confirm that he did not wish anyone to resuscitate him if his heart or breathing stopped.
17. Healthcare staff saw Mr Mouncer daily. Mr Mouncer said that he did not want to go to hospital or have any medical treatment other than to make him comfortable. A palliative nurse saw Mr Mouncer regularly and assisted him with his daily needs.
18. On 19 October, the prison submitted an application for Mr Mouncer's early release on compassionate grounds to the Public Protection Casework Section (PPCS) of HMPPS.
19. On 1 November, doctors told Mr Mouncer that his cancer had spread to his brain and bladder and no further treatment could be offered to him. A social care referral was made to ensure any additional care needs were identified.
20. On 9 December, a palliative nurse reviewed Mr Mouncer. He said his preferred place of death was in a hospice but he understood he may die in prison.
21. On 4 January 2023, PPCS refused Mr Mouncer's application for early release on compassionate grounds as they assessed that he could still present a risk to children. On 12 January, Mr Mouncer spoke to a nurse about the decision and said he would like to die at Norwich instead of in a hospice.
22. On 13 March, the prison approved an open door policy for Mr Mouncer, which enabled staff to access his cell at all times. His health was deteriorating and he was being nursed in bed. At the end of March, nursing staff began end of life care.
23. At 1.35am on 4 April, healthcare staff checked on Mr Mouncer and found that he was not breathing. A nurse was unable to detect a pulse. An ambulance was requested, and at 2.27am, paramedics pronounced that Mr Mouncer had died.

## **Post-mortem report**

24. The coroner accepted the cause of death provided by a GP at Norwich and no post-mortem examination was carried out. The GP gave Mr Mouncer's cause of death as metastatic cancer of the prostate (cancer that has spread to other parts of the body).

**Adrian Usher**  
**Prisons and Probation Ombudsman**

**November 2023**

## **Inquest**

The inquest, held on 13 December 2023, concluded that Mr Mouncer died from natural causes.

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