

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Frank Salmon, a prisoner at HMP Channings Wood, on 6 August 2023

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



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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 Frank Salmon died of occlusion of coronary artery bypass grafts (blocking of the blood vessel that was inserted into the coronary artery to improve blood supply to the heart) due to atherosclerosis (narrowing of the arteries caused by fatty deposits) on 6 August 2023 at HMP Channings Wood. He was 55 years old. We offer our condolences to Mr Salmon's family and friends.
4. The PPO family liaison officer wrote to Mr Salmon'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 Salmon's clinical care at Channings Wood. She concluded that the clinical care Mr Salmon received at Channings Wood was of a reasonable standard and was at least equivalent to that which he could have expected to receive in the community. However, she found the management of Mr Salmon's long-term conditions and care plans were not of the required standard and not equivalent to that which he could have expected to receive in the community.
6. The PPO investigator investigated the non-clinical issues relating to Mr Salmon's care. We did not find any non-clinical issues of concern.

Recommendation

- The Head of Healthcare should review the process for managing and monitoring long-term conditions to ensure the development of meaningful patient-centred care plans.
7. We shared our initial report with HMPPS. They found no factual inaccuracies. They provided an action plan which is annexed to this report.
 8. We sent a copy of our initial report to Mr Salmon's next of kin. They did not notify us of any factual inaccuracies.

Adrian Usher
Prisons and Probation Ombudsman

February 2024

Inquest

The inquest, heard on 16 July 2024, concluded that Mr Salmon died from natural causes.

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