Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Brian Heron, a prisoner at HMP Frankland, on 14 January 2025

A report by the Prisons and Probation Ombudsman

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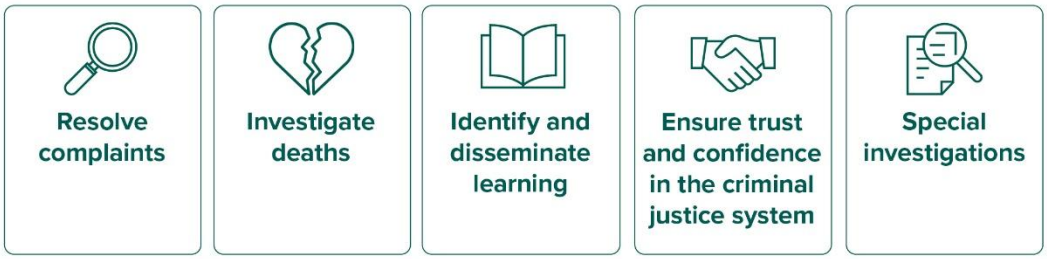
OUR VISION

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 8 August 2019, Mr Brian Heron was sentenced to 14 years in prison for sexual offences. He died in hospital of respiratory failure due to respiratory syncytial virus infection on a background of chronic obstructive pulmonary disease, on 14 January 2025, while a prisoner at HMP Frankland. He was 78 years old. We offer our condolences to Mr Heron's family and friends.

4. The Ombudsman's office wrote to Mr Heron'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 Heron's clinical care at HMP Frankland.

6. The clinical reviewer concluded that the clinical care Mr Heron received at Frankland was of a reasonable standard and least equivalent to that which he could have expected to receive in the community. He found that Mr Heron medical records contained evidence of excellent individualised end of life care planning. The clinical reviewer made recommendations not related to Mr Heron's death that the Head of Healthcare will wish to address.

7. The PPO investigator investigated the non-clinical issues relating to Mr Heron's care. We did not find any non-clinical issues of concern.

8. The initial report was shared with HMPPS, Healthcare (Spectrum, Community Health CIC) and Mr Heron's next of kin. They did not identify any factual inaccuracies.

9. At the inquest held on 23 March 2026, the coroner concluded that Mr Brian Heron died of natural causes.

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

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