

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Brian Teasdale, a prisoner at HMP Holme House, on 16 September 2019

**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*



© Crown copyright 2018

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit [nationalarchives.gov.uk/doc/open-government-licence/version/3](http://nationalarchives.gov.uk/doc/open-government-licence/version/3) or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: [psi@nationalarchives.gsi.gov.uk](mailto:psi@nationalarchives.gsi.gov.uk).

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

## 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. My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Brian Teasdale died on 16 September 2019 of metastatic bladder cancer at HMP Holme House. He was 69 years old. I offer my condolences to his family and friends.
4. The clinical reviewer concluded that the care Mr Teasdale received at Holme House was equivalent to that which he could have expected to receive in the community. She made one recommendation about GPs delivering all aspects of palliative care.
5. We did not find any non-clinical issues of concern.

## Recommendation

- Spectrum, as the provider of medical care at Holme House, should ensure that GPs deliver all aspects of palliative care effectively, including prescribing anticipatory medicines and seeking advice out-of-hours so that anticipatory medicines are prescribed in a timely and responsive manner.

## The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Teasdale's clinical care at HMP Holme House. The clinical reviewer's clinical review is annexed to this report.
7. A PPO investigator has investigated non-clinical issues, including Mr Teasdale's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. Our family liaison officer wrote to Mr Teasdale's next of kin to explain the investigation and to ask whether he had any matters he wanted us to consider. He did not respond to our letter.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.
10. This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

### Previous deaths at HMP Holme House

11. Mr Teasdale's death was the thirteenth at Holme House since September 2017. Of those deaths, nine were from natural causes. Since Mr Teasdale died, there have been nine more deaths at Holme House, seven of which were from natural causes. There are no similarities between Mr Teasdale's death and the previous deaths at Holme House.

## Key Events

12. Mr Brian Teasdale had been serving time in prison for sexual offences at HMP Northumberland since February 2017. He was transferred to HMP Holme House on 3 September 2019.
13. Between March 2017 and January 2019, while at Northumberland, Mr Teasdale had symptoms that indicated he had bladder cancer. He repeatedly refused further investigation or intervention.
14. On 5 July, Mr Teasdale's health deteriorated and he was transferred to hospital. He had surgery to prevent / treat obstruction of the flow of urine from the kidney.
15. While in hospital, biopsies confirmed that Mr Teasdale had bladder cancer.
16. On 7 August, Mr Teasdale was discharged to Northumberland but his health continued to deteriorate and on 14 August, he was transferred to a second hospital.
17. On 23 August, Mr Teasdale was transferred to a third hospital for palliative care as it was thought that he was nearing the end of his life.
18. Mr Teasdale's health unexpectedly improved but he was unable to return to Northumberland as they did not have 24-hour healthcare facilities.
19. On 3 September, Mr Teasdale was transferred to Holme House as they had 24-hour healthcare facilities. He lived in the Palliative Care Suite, where he received end-of-life care.
20. On 10 September, Mr Teasdale stated that his preferred place of death was Holme House and that he did not want to be resuscitated if his heart stopped beating.
21. Mr Teasdale's health deteriorated, and he died on 16 September 2019.

### Post-mortem report

22. A post-mortem examination was not conducted. A doctor confirmed Mr Teasdale's death and the Coroner accepted the cause of death as metastatic bladder cancer.

## **Clinical findings**

23. The independent clinical reviewer concluded that the care that Mr Teasdale received was equivalent to that which he could have expected to receive in the community. She made one recommendation to Spectrum, who are responsible for providing GP and pharmacy services at Holme House (nursing and support healthcare is provided by G4S), about GPs delivering all aspects of delivering palliative care. The clinical reviewer's findings are set out in her report at Annex 1.

**Caroline Mills**

**Prisons and Probation Assistant Ombudsman**

**December 2020**

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations