Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Terence Townsend, a prisoner at HMP Buckley Hall, on 15 February 2025

A report by the Prisons and Probation Ombudsman

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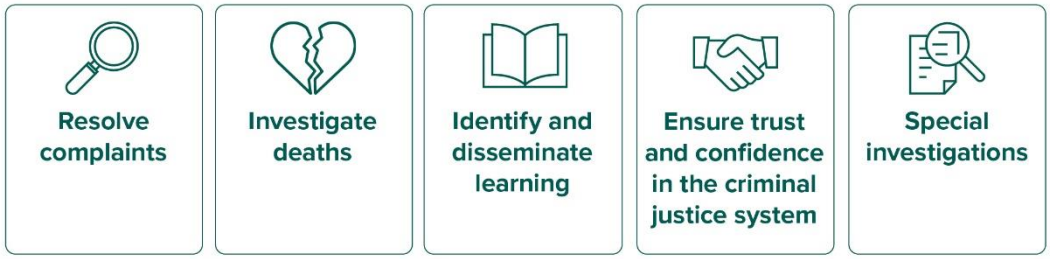
OUR VISION

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. In December 2007, Mr Terence Townsend was sentenced to life in prison for murder. He died from a hemopericardium (the presence of blood in the pericardial sac around the heart) on 15 February 2025, while a prisoner at HMP Buckley Hall. This was caused by a ruptured acute myocardial infarction (a split/tear in the heart). He was 68 years old. We offer our condolences to Mr Townsend's family and friends.

4. The Ombudsman's office wrote to Mr Townsend'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 Townsend's clinical care at Buckley Hall.

6. The clinical reviewer concluded that the clinical care Mr Townsend received at Buckley Hall was of a reasonable standard and was equivalent to that which he could have expected to receive in the community. The clinical reviewer made six recommendations which were not related to Mr Townsend's death but which the Head of Healthcare will want to address.

7. The PPO investigator investigated the non-clinical issues relating to Mr Townsend's care.

8. We did not identify any non-clinical learning and we make no recommendations.

9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

10. Mr Townsend's family received a copy of the draft report. They did not make any comments.

Record of inquest

11. The inquest into Mr Townsend's death was held on 18 July 2025 and a verdict of natural causes was recorded. The Coroner concluded that Mr Townsend died from a hemopericardium, caused by Ruptured Acute Myocardial Infarction (a tear in the heart following a heart attack) and Severe coronary artery atherosclerosis (narrowing of arteries).

Governor to note

12. We asked the prison to provide us with the cell bell records for Mr Townsend but we were told that it could not be provided as the equipment was located in the roof and was inaccessible. We bring this matter to the Governor's attention.

Adrian Usher
Prisons and Probation Ombudsman **August 2025**

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