Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Terrance Lightbourne, a prisoner at HMP Preston, on 24 July 2022

A report by the Prisons and Probation Ombudsman

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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

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. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

3. Mr Terrance Lightbourne died in hospital of sepsis and septic shock on 24 July 2022, while a prisoner at HMP Preston. He was 39 years old. We offer our condolences to Mr Lightbourne's family and friends.

4. The clinical reviewer concluded that the care that Mr Lightbourne received at HMP Preston was of a good standard and equivalent to that which he could have expected to receive in the community. She made no recommendations but found good practice in the pharmacy technician's early detection that Mr Lightbourne was acutely unwell and that this was appropriately reported to healthcare staff.

5. We did not find any non-clinical issues of concern.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Lightbourne's clinical care at HMP Preston.

7. The PPO investigator has investigated non-clinical issues, including Mr Lightbourne's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

8. The Ombudsman's family liaison officer wrote to Mr Lightbourne's next of kin, his friend, to explain the investigation and to ask if he had any issues 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 pointed out some factual inaccuracies in the clinical review, which has been amended accordingly.

Previous deaths at HMP Preston

10. Mr Lightbourne was the fifth prisoner to die at Preston since July 2020. Of the previous deaths, two were from natural causes and two were self-inflicted.

Key Events

10. On 4 May 2021, Mr Terrance Lightbourne was remanded into custody, charged with affray, indecent exposure, property damage and assault. He was in the UK on an expired visitor's visa from the Bahamas. He was sent to HMP Preston.

11. A nurse carried out an initial health screen. He noted that before he arrived in prison, Mr Lightbourne had been an inpatient at a mental health hospital. He told the nurse that he had been diagnosed with bipolar disorder in the Bahamas. However, staff at the mental health hospital diagnosed him with mania (periods of abnormally elevated and extreme changes in mood, emotions or energy level). The nurse noted that Mr Lightbourne had a long history of cannabis misuse. The nurse referred him to the prison's mental health inreach team who saw him the following day. She created a care plan for his ongoing monitoring and support.

12. On 14 June, Mr Lightbourne was sentenced to 16 weeks in prison. On 28 June, he was released from Preston and went to live at an approved premises in Carlisle. However, on 30 June, he breached his licence conditions and was recalled to prison. He was sent to HMP Durham.

13. Over the following months, Mr Lightbourne was transferred between a number of prisons and a mental health hospital due to his disruptive and threatening behaviour and his refusal to engage. He was eventually sent from a mental health hospital to HMP Preston on 11 February 2022.

14. A nurse carried out an initial health screen. She noted Mr Lightbourne's mental health history and cannabis misuse and referred him to the prison's mental health inreach team for further review. They saw Mr Lightbourne regularly and created a care plan to support and monitor him.

15. On 5 May, Mr Lightbourne was sentenced to a further four weeks in prison for damaging a vehicle while at the mental health hospital.

16. On 20 July, a pharmacy technician took Mr Lightbourne's prescribed medications to his cell and noted that he appeared unwell. He told that her he thought it was effects of his medication. She asked a nurse to review him.

17. At 6.35pm, a nurse saw Mr Lightbourne. She took a note of his observations and recorded that his temperature and pulse were high. She administered oxygen therapy and his oxygen saturation level improved. She arranged for Mr Lightbourne to go to hospital by ambulance, but the Ambulance Service was experiencing a high volume of calls and said that they would attend as soon as they were able.

18. At 7.45pm, a nurse noted that the stocks of oxygen in the healthcare department were almost depleted. She telephoned the Ambulance Service for an update. The Ambulance Service escalated the request for an ambulance to urgent.

19. At 8.22pm, the emergency ambulance arrived at the prison and after paramedics reviewed his condition, Mr Lightbourne was taken to hospital at 9.05pm.

20. Mr Lightbourne was admitted to hospital as an inpatient. He was diagnosed with sepsis (a life-threatening reaction to infection) and bacterial pneumonia.

21. At 2.54am on 21 July, Mr Lightbourne's condition deteriorated in hospital, and he was moved to the intensive care unit. He was sedated and placed on a ventilator to help him breathe. Hospital staff told the prison staff who accompanied that his prognosis was poor.

22. At 8.05pm on 24 July, the ventilator was removed and, at 8.10pm, a hospital doctor confirmed that Mr Lightbourne had died.

Cause of death

23. A hospital doctor established that Mr Lightbourne had died from sepsis and septic shock caused by multi-organ dysfunction, acute respiratory dysfunction and acute kidney injury. The coroner accepted the cause of death, and no post-mortem examination was carried out.

Inquest into Mr Lightbourne's death

24. The inquest into Mr Lightbourne's death was held on 9 June 2023 and a verdict of natural causes was recorded.

25. The coroner concluded Mr Lightbourne's death was due to septic shock and severe community acquired pneumonia.

Lisa Burrell **June 2023**
Assistant Ombudsman

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