Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Lancaster, on 30 November 2022, following his release from HMP Durham

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

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. Since 6 September 2021, the PPO has been investigating post-release deaths that occur within 14 days of the person's release from prison.

3. If my office is to best assist HMPPS in ensuring the standard of care received by those within service remit is appropriate then our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic process failures.

4. Mr David Lancaster died of hanging on 30 November 2022, following his release from HMP Durham on 28 November. He was 42 years old. We offer our condolences to those who knew him.

5. Mr Lancaster had a long history of offending. He had been in and out of prison for various offences, including harassment and violence related offences. He experienced depression and anxiety and was diagnosed with post-traumatic stress disorder (PTSD). He had attempted suicide on several occasions while in the community.

6. We are satisfied that there was little to indicate that Mr Lancaster was at heightened risk of suicide in the time leading up to his death or that there was any specific risk information that should have been shared between prison staff and his community offender manager or support agencies.

7. We did not find any issues of concern.

The Investigation Process

8. We were notified of Mr Lancaster's death on 30 June 2023 (eight months after his death). The prison was also informed on the same day, and we do not know the reason for the delay.

9. The PPO investigator obtained copies of relevant extracts from Mr Lancaster's prison and probation records.

10. We informed HM Coroner for Hartlepool of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

11. The Ombudsman's family liaison officer contacted Mr Lancaster's next of kin to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.

12. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found no factual inaccuracies in the report.

Background Information

HMP Durham

13. HMP Durham is a local prison, serving the courts of Tyneside, Durham and Cumbria. It holds approximately 1,000 male prisoners. Spectrum Community Health CIC provides primary healthcare services. Tees, Esk and Wear Valleys Foundation NHS Trust provides mental health services.

Probation Service

14. The Probation Service work with all individuals subject to custodial and community sentences. During a person's imprisonment, they oversee their sentence plan to assist in rehabilitation, as well as prepare reports to advise the Parole Board and have links with local partnerships to whom, where appropriate, they refer people for resettlement services. Post-release, the Probation Service supervise people throughout their licence period and post-sentence supervision.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Durham was in November 2021. Inspectors reported that the quality of support delivered through Assessment, Care in Custody and Teamwork (ACCT) case management for at-risk prisoners varied. Inspectors also reported that contact between prison offender managers and prisoners was poor, although release plans were of good quality.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 31 October 2022, the IMB reported that prison offender manager clinics have started on each wing, to allow prisoners direct access to offender managers.

Key Events

17. On 24 November 2021, Mr David Lancaster was sentenced to an 18-month community order for harassment. The order was due to expire in May 2023.

18. In August 2022, Mr Lancaster secured a tenancy in Hartlepool, which remained his address until his death. He had moved to Hartlepool to be closer to the support of his family. In August, management of Mr Lancaster's community order was transferred to a community offender manager (COM). Mr Lancaster had diagnoses of depression, anxiety and post-traumatic stress disorder (PTSD). He also told probation staff that his brother had taken his life some years previously.

19. Mr Lancaster had a history of substance misuse. He had previously engaged with a Drug and Alcohol Recovery Team (DART), attending regular sessions and appointments to address his drug misuse via relapse prevention intervention. During previous prison sentences, Mr Lancaster had engaged with substance misuse services, including a Cocaine Anonymous course.

20. On 12 November, Mr Lancaster was remanded in custody to HMP Durham, on charges of criminal damage and harassment. Prison staff started suicide and self-harm prevention procedures (known as ACCT) as Mr Lancaster said that he had attempted suicide a few months ago.

21. Mr Lancaster was not allocated a prison offender manager (POM), due to his remand status. Probation staff confirmed that when Mr Lancaster was remanded to Durham, his COM had no further contact with him.

22. On 13 November, Mr Lancaster attended an ACCT case review. Mr Lancaster said that he was coping well in prison and that he felt safer and calmer in custody. He stated he felt 'stupid' about his previous suicide and self-harm attempts and had no current thoughts of them as he wanted to be there for his family. Mr Lancaster said he had plans of working towards gaining access to his children and also working while in prison and when released. Prison staff agreed to close the ACCT procedures.

23. On the same day, a mental health nurse assessed Mr Lancaster. She recorded his diagnoses and that he was prescribed antidepressants. (This prescription was continued in prison.) The nurse concluded that Mr Lancaster had no current mental health needs that required further input from the mental health team.

24. On 14 November, staff from the prison's substance misuse service spoke with Mr Lancaster as part of a non-clinical DART induction process. Mr Lancaster declined to engage with them, stating he had no issues with drugs or alcohol. DART staff discussed harm reduction with Mr Lancaster, which included risks of illicit substance use, risks of reduced tolerance levels and overdose awareness. They made Mr Lancaster aware of the self-referral process should he decide that he wished to engage with their services.

25. On 23 November, Mr Lancaster met with a probation worker in prison. No issues were raised throughout the session.

26. On 28 November, Mr Lancaster attended a court appearance by video link. He was convicted of criminal damage and harassment and received a suspended sentence with a community order. Prison staff recorded that Mr Lancaster raised no issues or concerns after this. He was released from custody that day.

Post-release

27. Probation informed us that Mr Lancaster's release was not a standard release from custody on licence, when there is an expectation of a first appointment on the day of release, or the next working day. Mr Lancaster was released from remand to start a suspended sentence order in which the requirement was to have an initial contact within five working days of sentence. Therefore, Mr Lancaster would have had an appointment by 5 December at the latest. However, due to Mr Lancaster's death very soon after release, there was no time for this to happen.

28. Mr Lancaster already had a sentence plan from his previous sentence in November 2021, which should have been reviewed within 15 days of the start of his new sentence. Probation staff reported that the issues that needed work on Mr Lancaster's sentence plan included relationships, substance misuse and emotional wellbeing/PTSD. Mr Lancaster was also supported by the mental health crisis team who encouraged him to continue working with them for ongoing support.

Circumstances of Mr Lancaster's death

29. Mr Lancaster was last seen at around 4.00am on 29 November, by a friend who had not subsequently been able to contact him. On 30 November, Mr Lancaster's uncle visited his home address and found him hanging. Paramedics attended and declared Mr Lancaster deceased.

Post-mortem report

30. The post-mortem report concluded that Mr Lancaster died of pressure on the neck caused by hanging. The toxicology report found a level of cocaine in Mr Lancaster's blood in the range associated with fatality.

Findings

31. Mr Lancaster had some risk factors for suicide and self-harm. He had previously attempted suicide, he had a history of substance misuse, and he had been diagnosed with anxiety, depression and PTSD. Mr Lancaster also described a family history of suicide.

32. Probation staff told us that they identified that Mr Lancaster was at risk of self-harm, including that he had threatened to take his life at the time of his offence.

33. Mr Lancaster had declined to engage with prison substance misuse services, stating he had no current issues with drugs or alcohol.

34. Although he had these risk factors, we are satisfied that there was little to indicate that Mr Lancaster was at heightened risk of suicide in the time before his release from prison, or that there was any specific risk information that should have been shared between prison and probation staff or support agencies.

Inquest

35. The inquest into Mr Lancaster's death concluded on the 28 April 2024. The coroner confirmed that Mr Lancaster died by suicide.

Adrian Usher
Prisons and Probation Ombudsman **November 2024**

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