Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Carl Langdell, a prisoner at HMP Wakefield, on 11 February 2021

**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

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.

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

Mr Carl Langdell died on 11 February 2021 from a haemorrhage after he cut his neck in his cell at HMP Wakefield. He was 31 years old. I offer my condolences to Mr Langdell's family and friends.

Mr Langdell had a history of mental ill health and had spent nearly two years in a high security psychiatric hospital before transferring to Wakefield. He also had a history of significant self-harm, although he had last self-harmed in May 2019.

In early December 2020, Mr Langdell stopped taking his psychiatric medication. Over the following weeks, his behaviour deteriorated and was described as "bizarre", and he became more withdrawn. We are concerned that staff did not consider starting suicide and self-harm monitoring procedures, known as ACCT.

Mr Langdell was serving a life sentence for murder. The day before his death, he declined to take part in the inquest into the death of his victim. This may have been a further opportunity to assess his risk of suicide.

I am also concerned that the very restrictive regime introduced in response to the COVID-19 pandemic meant that staff had no meaningful engagement with Mr Langdell in the months before he died. The regime might also have had an impact on his mental health.

The clinical reviewer also found that the mental health team missed opportunities to review Mr Langdell in the days leading to his death.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

**Elizabeth Moody**
**Deputy Prisons and Probation Ombudsman** **May 2022**

# Contents

# Summary

## Events

1. On 26 December 2015, Mr Carl Langdell was remanded into custody. He was convicted of murder in early 2016. In July 2017, Mr Langdell was admitted to Rampton High Security Hospital.

2. Mr Langdell was discharged to HMP Wakefield in May 2019. Soon after he arrived at Wakefield, he made a significant cut to his neck and he was monitored under suicide and self-harm procedures (known as ACCT).

3. Mr Langdell kept to himself, did not mix with other prisoners and only approached staff when he needed something. In December 2020, Mr Langdell began refusing to take his psychiatric medication and, over the following weeks, his behaviour deteriorated, and he became more withdrawn. The day before his death, Mr Langdell was asked if he wanted to take part in the upcoming inquest into the death of his victim. He declined.

4. Just after midnight on 11 February 2021, an officer found Mr Langdell in his cell with a substantial cut to his neck. He was still conscious. Officers and nurses initially treated Mr Langdell and they were later assisted by paramedics. However, during treatment, Mr Langdell's condition deteriorated and their efforts to save his life were unsuccessful. Mr Langdell's death was confirmed at 1.47am.

## Findings

5. Although Mr Langdell kept to himself and did not participate fully in prison life even before the COVID-19 pandemic, his behaviour began to change from the time that he stopped taking his psychiatric medication in December 2020. Although staff could not reasonably have known that he was at imminent risk of suicide on the evening of his death, we are concerned that staff did not consider starting ACCT procedures for him when his behaviour deteriorated and there were concerns about his mental health in the weeks before he died.

6. The very restricted COVID-19 regime also meant that Mr Langdell spent at least 22 hours a day alone in his cell, and this might also have affected his mental health.

7. We are concerned that staff did not adequately consider if Mr Langdell's risk had increased after he was asked to attend his victim's inquest. This was a further missed opportunity to assess whether Mr Langdell was at an increased risk of suicide or self-harm.

8. We are also concerned that the daily welfare checks on prisoners during the restricted regime did not provide an opportunity for meaningful conversations in which Mr Langdell might have shared his concerns with officers or in which officers might have identified his low mood.

9. The clinical reviewer considered that the mental health team missed an opportunity to review Mr Langdell in the days before his death. He concluded that the

healthcare Mr Langdell received at Wakefield was of a mixed standard and not fully equivalent to that which he could have expected to receive in the community.

## Recommendations

- **The Governor and Head of Healthcare should ensure that staff consider all relevant risk information about prisoners when assessing their risk of suicide and self-harm and start ACCT procedures when appropriate.**

- **The Governor and Head of Healthcare should ensure that prisoners are assessed after a significant event (such as an invitation to attend an inquest) to assess their risk of suicide or self-harm.**

- **The Governor should ensure that staff understand the importance of having meaningful conversations with prisoners where possible, including when carrying out welfare checks during the restricted regime.**

- **The Head of Healthcare and the Governor should review the internal communication systems used within the prison to ensure that clear processes are in place to refer prisoners to mental health services.**

- **The Head of Healthcare should ensure that all staff are aware of the requirement to maintain full and contemporaneous healthcare records.**

- **The Governor and Head of Healthcare should ensure that a copy of this report is shared with all staff named in this report and that a senior manager discusses the Ombudsman's findings with them.**

## The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Wakefield informing them of the investigation and asking anyone with relevant information to contact him. No one responded

11. The investigator obtained copies of relevant extracts from Mr Langdell's prison and medical records.

12. NHS England commissioned a clinical reviewer to review Mr Langdell's clinical care at the prison.

13. The investigator interviewed twelve members of staff and two prisoners at Wakefield, some jointly with the clinical reviewer. All the interviews were conducted remotely either by video or by telephone because of the restrictions imposed as a result of COVID-19.

14. We informed HM Coroner for West Yorkshire Eastern District of the investigation. He provided us with a copy of the post-mortem report. We have sent him a copy of this report.

15. We contacted Mr Langdell's family to explain the investigation and to ask if they had any matters they wanted us to consider. They asked why Mr Langdell had access to a razor blade, given his history of mental health and self-harm issues. They also asked what medication he was taking at the time of his death. We have addressed these issues in this report and in the clinical review.

16. Mr Langdell's family received a copy of the initial report. They did not make any comments.

# Background Information

## HMP Wakefield

17. HMP Wakefield is a high security prison and holds up to 750 prisoners, mostly serving sentences of more than ten years. Practice Plus Group provides 24-hour healthcare and social care services. Service provision for psychiatry, recovery and psychology services are contracted from the Midlands Partnership NHS Foundation Trust.

## HM Inspectorate of Prisons

18. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Wakefield in June 2018. Inspectors reported that despite the prison holding some of the most challenging and complex prisoners in the country, the prison was calm and had an atmosphere that spoke of good order, safety, security and decency, although some prisoners complained that staff were not visible or engaged enough.

19. Inspectors reported that mental health services offered a good range of group activities and psychological support for mild to moderate conditions, but that support for more complex cases was more variable. HMIP reported that there was an open referral system, with urgent cases being seen within 24 hours and routine referrals being triaged within 72 hours.

20. HMIP concluded that the high standards, good practice and improvements achieved at Wakefield were the result of hard work and dedication of staff who took seriously their responsibilities for the safe, secure and purposeful imprisonment of prisoners in their care.

## Independent Monitoring Board

21. 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 April 2020, the IMB reported that they generally considered HMP Wakefield to be a calm environment, despite its challenging prisoner mix and changing population profile.

## Previous deaths at HMP Wakefield

22. Mr Langdell was the third prisoner to take his life at Wakefield since January 2015. In our investigations into the two previous self-inflicted deaths (in November 2018 and June 2019), we found that the circumstances were not similar to those of Mr Langdell's death. There has been one further self-inflicted death at the prison since Mr Langdell's.

## Assessment, Care in Custody and Teamwork

23. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk,

how to reduce the risk and how best to monitor and supervise the prisoner. As part of the process, a risk reduction plan, also known as a caremap (a plan of care, support and intervention) should be put in place. The ACCT plan should not be closed until all the actions of the risk reduction plan have been completed. After closure, a follow-up interview should take place within seven days.

24. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Prison Service Instruction (PSI) 64/2011 on safer custody sets out how staff should operate ACCT procedures.

## Covid-19 restrictions

25. On 24 March 2020, in response to the COVID-19 pandemic and in line with Government advice, HM Prison and Probation Service (HMPPS) issued an instruction to all prisons to introduce social distancing and a restricted regime for staff and prisoners, wherever possible. On 27 March, HMPPS issued operational guidance to prisons on exceptional regime and service delivery, which reflected Government restrictions following the national lockdown of 23 March. This guidance resulted in significantly restricted prisoner activities. Prison visits were suspended, education and non-essential work was cancelled, and healthcare delivery was also affected. This meant that prisoners spent much of their day locked behind their cell doors.

## Keyworker scheme

26. The keyworker scheme aims to improve safer custody by engaging with prisoners, building better relationships between staff and prisoners and helping prisoners settle into life in prison. It provides that all adult male prisoners will be allocated a key worker who will spend an average of 45 minutes a week on key worker activities, including having meaningful conversation which each allocated prisoner.

27. The key worker scheme was suspended across the estate on 24 March 2020, due to the COVID-19 pandemic. To ensure that meaningful interaction continued for priority prisoners, such as those who were at risk of suicide or self-harm, the Prison Service introduced the Exceptional Delivery Model for keywork in May 2020. This provides that an officer will have a weekly conversation with prisoners identified as vulnerable.

# Key Events

## Background

28. On 26 December 2015, Mr Carl Langdell was remanded in custody at HMP Bedford, charged with murder.

29. In January 2016, while on remand at HMP Frankland, Mr Langdell told healthcare staff that he would prove he was mentally ill by killing someone, before taking his own life. He later harmed himself by cutting and needed hospital treatment. Mr Langdell was also violent on several occasions and assaulted officers. In March 2016, Mr Langdell was convicted and sentenced to 26 years in prison.

30. He was diagnosed with emotionally unstable, dissocial and obsessive-compulsive personality disorders.

31. In June 2016, Mr Langdell reported that he was receiving subliminal messages, described delusional ideas and reported psychotic symptoms. A psychiatrist at Frankland referred Mr Langdell to Rampton High Security Hospital and he was transferred in July 2017. In hospital, Mr Langdell made further significant attempts to harm himself and threatened to harm staff. After treatment at Rampton, a hospital psychiatrist concluded that Mr Langdell did not have a psychotic illness and had fabricated delusional thoughts and recommended that he should continue to serve his sentence in prison.

## HMP Wakefield

32. In May 2019, Mr Langdell was discharged from Rampton and transferred to HMP Wakefield. When Mr Langdell arrived at Wakefield, a nurse noted that he had no physical health concerns but referred him to the prison's mental health team. Mr Langdell's medication, prescribed at Rampton, including venlafaxine (an antidepressant) and promethazine (an antihistamine with sedative properties) was re-prescribed.

33. Days after his arrival at Wakefield, Mr Langdell tried to take his life by making a substantial cut to his neck. He was treated in hospital and staff monitored him under ACCT procedures.

34. On 3 June, a consultant forensic psychiatrist noted that Mr Langdell should continue taking the medication prescribed at Rampton. He noted that in the absence of any mental illness, he would not review Mr Langdell again unless requested, that the prison GP would continue to prescribe venlafaxine and promethazine, and that Mr Langdell's chronic risk of suicide and self-harm, due to his personality disorder, should be managed through ACCT, as necessary.

35. Mr Langdell was reluctant to engage in the ACCT process and refused to attend eleven of the thirteen ACCT reviews held. He also stopped engaging with healthcare staff. ACCT procedures were stopped in November 2019.

36. In March 2020, Wakefield prison introduced several measures to manage the risk of the COVID-19 pandemic. These impacted on the prison's regime and significantly restricted prisoners' activities and time out of cell.

37. Mr Langdell had no significant involvement with the healthcare team, other than when collecting his medication. A mental health nurse tried to see him in May, as he had appeared more quiet than usual. However, a supervising officer (SO) advised that seeing her might aggravate Mr Langdell as there was no significant change in his presentation. The nurse introduced herself to Mr Langdell casually and noted that it was clear he did not want to talk to anyone.

38. In June, a mental health nurse saw Mr Langdell, but he refused to engage. In early July, a nurse noted concerns about Mr Langdell's perceived low mood and anxiety and that he felt anxious when out of his cell. On 22 July, Mr Langdell refused to take his venlafaxine medication.

39. On 27 August, a nurse noted that Mr Langdell was extremely drowsy and lethargic when he collected his medication. He was refused his promethazine as a result. Mr Langdell became aggressive, and officers restrained him and returned him to his cell. The nurse noted her concern that he might be misusing medication.

40. During the summer and autumn officers noted that Mr Langdell's interactions with staff continued to be limited, he only spoke to them when he needed something, he sometimes did not collect his medication and he did not use the facilities offered to him.

41. On 28 November, a nurse raised further concerns about Mr Langdell being drowsy when he collected his promethazine. The nurse refused to issue it and referred him for discussion at a complex case clinic meeting as Mr Langdell continued to request medication twice a day.

42. At a complex case clinic meeting on 2 December, it was noted that Mr Langdell had regularly asked for promethazine, which was only to be issued when Mr Langdell presented with symptoms of agitation. However, it was noted that there was no evidence that he was agitated and, also, that he had not taken his venlafaxine consistently. 2 December was the last time that he took his venlafaxine.

43. Also, on 2 December, the Coroner for Hertfordshire wrote to Mr Langdell to ask if he wanted to be a "person of interest" during the inquest into the death of his victim. (Although the letter was noted in an intelligence report, there is no evidence that anyone spoke to Mr Langdell about this.)

44. On 9 December, the prison pharmacy noted that Mr Langdell had not collected his venlafaxine since being refused his promethazine. They asked the consultant psychiatrist to review his medication. A mental health nurse tried to assess Mr Langdell, but he did not engage. He said he was fine and had no issues with his medication. The nurse discussed Mr Langdell with officers who told her that he did not mix much and often appeared asleep in his cell. The safer custody team later gave Mr Langdell a distraction pack to help him keep mentally occupied during the COVID-19 lockdown.

45. On 15 December, Mr Langdell told an officer during a welfare check that, despite the COVID-19 pandemic, “everything was good”.

46. On 21 December, the consultant psychiatrist reviewed Mr Langdell’s promethazine but did not see him in person. He noted that Mr Langdell had not appeared agitated until his promethazine prescription was stopped. Mr Langdell had also stopped taking venlafaxine.

47. On 23 December, a mental health nurse tried to assess Mr Langdell’s mental state as he had not been taking his medication and as officers had said that he slept most of the day. Mr Langdell did not engage with her and asked her to go away as he had no concerns. He said he had no intention of taking his venlafaxine and asked for it to be stopped. The nurse noted that Mr Langdell knew how to access support if needed. (This was the last contact that Mr Langdell had with mental health services at Wakefield.)

48. On 24 December, an officer noted that Mr Langdell continued to leave his cell daily and always went out for exercise.

49. On 3 January 2021, an officer noted after a welfare check that Mr Langdell had been quieter than usual and that he had not been taking his medication for a month. Mr Langdell told him that he was ‘okay’. The officer noted that because Mr Langdell slept during the day, as he often stayed up all night watching television, he sometimes did not collect his meal.

50. The officer told the investigator that Mr Langdell kept to himself and was a private and polite person who did not mix with other prisoners. He said that after Christmas 2020, Mr Langdell did not always go out for exercise and became more withdrawn. Officers said that there was no indication that Mr Langdell was being bullied or using illicit substances.

51. On 7 January, Mr Langdell asked an officer to tell healthcare staff that he no longer wanted medication. She told the investigator that if she tried to press Mr Langdell about it, he would just say, “I just don’t want them, just don’t want them,” and that because he did not want to talk about it, she thought she would “just leave it”. She said that at the start of the year, Mr Langdell was fine, interacted with staff, appeared normal and seemed himself, although in the last few months of his life, he had become more erratic.

52. On 11 January, an officer noted after a welfare check that Mr Langdell was well. The following day, an officer made an identical entry about Mr Langdell’s welfare. On 14 January, an officer noted that Mr Langdell appeared to be coping well with the COVID-19 lockdown.

53. On 19 January, an officer noted that Mr Langdell followed the wing regime well, used the showers and telephone, exercised, collected his meals from the servery on most days, was quiet and did not mix with other prisoners.

54. On 21 January, Mr Langdell’s behaviour deteriorated, he spat at anyone who walked past his cell and shouted that he would hurt or kill anyone who went into his cell. An officer said that Mr Langdell calmed down in the afternoon and apologised to staff for his behaviour, saying that he had been in a bad mood when he woke up.

The officer said that by the afternoon, Mr Langdell had gone back to normal, was quiet and that the incident was “out of the blue”.

55. On 25 January, an officer noted that Mr Langdell was verbally abusive when he was asked if he wanted his medication. Another officer noted that when Mr Langdell was asked if he wanted his lunch, he jumped out of bed and declined, using abusive language. He noted that Mr Langdell’s behaviour was “bizarre”.

56. In the afternoon, Mr Langdell spat at an officer when she went to answer his cell bell. He was checked more regularly than usual that afternoon because he had blocked his observation panel. (An officer noted that staff used the cell fire inundation point to check on Mr Langdell.)

57. That evening, an officer recorded that the day staff had asked him to check on Mr Langdell because of his behaviour during the day. He recorded that Mr Langdell made noises and incoherent sounds when he called his name, but that he had no concerns about his welfare.

58. On the evening of 28 January, an officer noted that Mr Langdell seemed genuinely annoyed and irritated, but calm, when staff offered to take him to collect his medication. Mr Langdell repeated that he did not want to take his medication and asked to be removed from the medications list, so he was not disturbed. She noted that Mr Langdell’s previous non-compliance in taking medication had been linked to staff assaults and serious self-harm attempts.

59. The officer told a pharmacy technician about her contact with Mr Langdell. The pharmacy technician then spoke to staff on the wing who told her that Mr Langdell did not want any interaction with healthcare staff. (She told the investigator that she shared the information with healthcare colleagues, and it was discussed at the daily healthcare meeting.)

60. On 29 January, an officer told the investigator that due to Mr Langdell’s erratic behaviour, staff referred him to the mental health team for assessment. Another officer emailed a forensic psychologist to say that that staff were concerned that Mr Langdell had started displaying unusual and quite “bizarre behaviour”, he continued to refuse to take his medication, did not leave his cell, rarely collected his meals and slept most of the day.

61. The forensic psychologist responded immediately and asked a trainee psychologist assigned to Mr Langdell’s wing to review him and to make a simple care plan. She copied a senior mental health nurse into the email. The senior mental health nurse responded and invited the trainee psychologist to a referral meeting on 2 February. (There is no record that Mr Langdell was discussed at this meeting. The trainee psychologist was unable to attend the meeting, as she did not work on Mondays and because she was asked to self-isolate due to COVID-19. She arranged to see Mr Langdell on her return to work on 11 February.)

62. The senior mental health nurse said she took no further action as she thought that the email was a request for a discussion rather than a mental health referral. She said that she did not consider forwarding the email as a formal referral to the mental health team.

63. On 8 February, the Hertfordshire Coroner's officer contacted the Head of Security and said that they had not had a response from Mr Langdell about whether he would take part in the inquest into the death of his victim.

64. The Head of Security emailed an officer, who he believed was Mr Langdell's keyworker, to ask Mr Langdell if he wanted to be involved in the inquest. In the email to the officer, he wrote, "Be careful, I suspect she is his Murder Victim I am aware his behaviour recently has not been good [sic]".

65. On 9 February, the officer, who had not had any significant contact with Mr Langdell since early January, said he asked Mr Langdell, who was in bed, if he wanted to attend the inquest. Mr Langdell replied, 'No, thank you'. The officer said he asked Mr Langdell again, that the offer was politely declined a second time and that Mr Langdell did not give a reason for declining.

66. A prisoner, who lived in the cell next to Mr Langdell, said that Mr Langdell did not speak to people, kept to himself and only really spoke to healthcare staff. He said that when Mr Langdell stopped taking his medication, he went "downhill" and became confrontational towards staff.

67. Another prisoner, who also lived in a cell next to Mr Langdell, said Mr Langdell was very reserved and stayed in his cell most of the time. He said that in the weeks before his death, Mr Langdell would sometimes bang on the cell wall, threaten to kill him, would block his observation panel and sometimes spat at staff. He said in the week before his death, Mr Langdell stopped collecting his meals but would eat food he had bought from the prison shop.

## 10 February 2021

68. At around 11.23am on 10 February, Officer A checked on Mr Langdell. She said that he refused to leave his cell to take a shower, which she said he usually took, or to exercise or to collect his medication. Officer B checked on him again at midday.

69. At around 2.30pm, both officers went to Mr Langdell's cell to check if he wanted any hot water. Mr Langdell told Officer A that he did not need any. While in his cell, she asked him why he was refusing to leave his cell. She said Mr Langdell replied "calmly" that he was 'okay' and did not need anything from her. She briefly checked on Mr Langdell again at around 4.25pm. (She said that the cell's observation panel was not blocked when she went to the cell.)

70. At around 4.33pm, Officer A went to Mr Langdell's cell, opened his cell door and asked him if he wanted his evening meal. Mr Langdell did not collect his meal and remained in his cell. She told the investigator that it was not unusual for prisoners not to collect their food from the servery as they often preferred to eat their own food bought from the prison shop, and she knew Mr Langdell had food in his cell. She said that Mr Langdell did not express any thoughts of self-harm during her contacts with him.

71. At 5.09pm, Officer B checked on Mr Langdell through the observation panel, and another officer did so seconds later. At around 6.56pm, Officer B checked on Mr Langdell again during the evening roll count, and was followed a minute later by Officer A.

72. A prisoner said that during the day, Mr Langdell had been shouting out at various times and had covered his observation panel, and that staff had kept asking him to uncover it. (The CCTV footage viewed by the police does not indicate that staff had issues with the observation panel being blocked during their checks on Mr Langdell during the day.)

73. At around 7.15pm, Officer C arrived on the wing for her night shift. She said she did not think that Mr Langdell was discussed during the handover between shifts. She said that she had spoken to Mr Langdell on numerous occasions and had always found him to be polite, but that he kept to himself.

74. At around 7.46pm, Officer C carried out the evening roll check. Although she could not specifically recall checking on Mr Langdell, she said he raised no concerns. (Her next scheduled check of Mr Langdell was due at around 5.00am during the early morning roll check.)

75. CCTV footage shows officers patrolling the wing during the evening, but due to poor lighting, it is not clear if Mr Langdell's cell was checked during this time. During the evening, Mr Langdell turned his cell light on several times for short periods.

76. At around 12.05am on 11 February, Officer C was walking down the landing when she heard a faint noise from one of the cells. She called out, "Who's shouting at me?" She said it was not unusual for prisoners to shout out at night for an officer if they were walking on the wing. She said no one responded. However, a colleague who had heard her call, asked the officer who she was talking to and they agreed to check the cells.

77. At around 12.06am, an officer walked past Mr Langdell's cell and noticed that the cell light was on. He looked into the cell and saw Mr Langdell lying on his bed, with what appeared to be a large pool of blood on the cell floor. Officer C called an emergency code red (indicating a medical emergency involving serious blood loss) and the control room called the ambulance service. A SO, who was nearby, arrived within 30 seconds and the officers entered the cell.

78. The officers found that Mr Langdell had made a significant cut to the right side of his neck and the SO used a towel to compress the wound. Mr Langdell, who was conscious, told the officers that he had used a razor blade to cut his neck because he was "sick of life". While he was being treated, Mr Langdell's manner changed, he told the officers that he did not want to die and was a "good person". Officer C removed two safety razor blades from the cell.

79. At around 12.15am, a nurse arrived at the cell. Officer C left the cell with the nurse to collect medical equipment before returning to help Mr Langdell. Paramedics arrived at around 12.18am and took over treatment. When paramedics were assessing and treating him, Mr Langdell became agitated and uncooperative. Another paramedic crew arrived and provided treatment. As they moved Mr Langdell from the cell to the ambulance at 1.07am, he went into cardiac arrest and paramedics started cardiopulmonary resuscitation (CPR). CPR continued as Mr Langdell was taken to hospital at around 1.30am. Attempts to resuscitate Mr Langdell were not successful and he died at 1.47am.

80. After Mr Langdell's death, police searched his cell. Although they did not find an explicit suicide note, they recovered a box of letters and papers some of which contained vague, but not explicit, references to "no longer being alive".

## Contact with Mr Langdell's family

81. In the early hours of 11 February, the Head of the Chaplaincy told Mr Langdell's parents of their son's death by telephone due to the COVID-19 pandemic. Wakefield maintained contact with Mr Langdell's family and, in line with national instructions, contributed to the costs of his funeral.

## Support for prisoners and staff

82. The Head of Reducing Reoffending debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. Staff subsequently reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Langdell's death.

## Post-mortem report

83. A post-mortem examination found that Mr Langdell died of an incised wound to the neck which led to haemorrhaging. Toxicology results established that Mr Langdell had not taken any substances that could be expected to have caused or contributed to his death.

# Findings

## COVID-19 restrictions

84. Guidance issued in response to the COVID-19 pandemic resulted in significantly restricted prisoner activities. Prison visits were suspended, education and non-essential work was cancelled, and healthcare delivery was also affected. This meant that prisoners at Wakefield spent up to 22 hours a day locked in their cells, only allowed out to exercise in the fresh air, have a shower and have limited association with other prisoners on their wing. Officers checked on prisoners during daily roll and welfare checks.

85. The guidance required prisons to make every effort to ensure resources were available to support prisoners subject to ACCT procedures, recognising that the risk of self-harm could increase as a result of prolonged periods in cells. It is difficult to determine what effect the COVID-19 restrictions may have had on Mr Langdell and how it affected his wellbeing and mental health. However, even before the restrictions were introduced, Mr Langdell spent most of his time in his cell, he seldom mixed with other prisoners and only engaged with staff when he needed something.

## Assessment of risk

86. Prison Service Instruction (PSI) 64/2011 on safer custody requires all staff who have contact with prisoners to be aware of the risk factors and triggers that may increase prisoners' risk of suicide and self-harm and take appropriate action. The PSI lists several risk factors and states that potential triggers should be continually assessed. It notes that any member of staff, who observes behaviour which may indicate a risk of suicide or self-harm, must start ACCT procedures.

87. Mr Langdell was not being monitored under ACCT procedures at the time of his death and had last been subject to them in November 2019. None of the prison staff we interviewed considered that Mr Langdell was at an increased level of risk of suicide or self-harm in the weeks before his death and Mr Langdell denied such thoughts.

88. However, since January 2021, Mr Langdell appeared to have become increasingly anxious, having refused his medication since early December 2020. Staff were aware of a change in his behaviour which was described as "bizarre", "erratic" and "unusual": he increasingly refused to leave his cell for exercise and to collect his meals, he had episodes of aggression and irritation, he blocked his observation panel, and he sometimes made incomprehensible noises. Officer B said that Mr Langdell was not displaying behaviour that would indicate that he was at particular risk of self-harm, he had not expressed his intention to self-harm and she did not consider that his demeanour had changed sufficiently to warrant starting ACCT procedures.

89. While staff judgement based on a prisoner's apparent mood and state of mind is important, it is only one indication of their risk. Staff should also recognise that prisoners often try to hide their distress, particularly in different settings and with

people they do not know. Assessments based on behaviour and presentation must, therefore, be balanced against the available risk information.

90. Mr Langdell had stopped taking his medication, which we consider is likely to have increased his risk of self-harm, and the mental health team had not seen him since 23 December. We recognise that officers would probably not have known about his lack of interaction with mental health services or why he no longer wanted his medication. However, they did know that he was not taking his medication and that his behaviour had changed to the extent that he was referred to the mental health team on 29 January. We consider that staff should have started ACCT procedures by at least late January, given the clear deterioration in his behaviour over a number of weeks and until the mental health team had assessed him.

91. By not starting ACCT procedures, staff missed an opportunity to identify if Mr Langdell's risk had increased. This in turn would likely have led to an assessment and multidisciplinary review of his needs. We appreciate that when Mr Langdell was previously monitored under ACCT procedures, he frequently refused to engage. Nevertheless, the safeguards would have remained in place whether or not he participated in the process.

92. Although we consider that there was clear evidence to indicate that Mr Langdell should have been monitored under ACCT procedures in the weeks leading to his death, we accept that it is unlikely that monitoring levels would have been sufficient to have prevented him from taking his life. We therefore do not consider that, on balance, prison staff could reasonably have prevented Mr Langdell's death. However, we make the following recommendation:

**The Governor and Head of Healthcare should ensure that staff consider all relevant risk information about prisoners when assessing their risk of suicide and self-harm and start ACCT procedures when appropriate.**

## Consideration of risk after change in circumstance

93. Prison Service Order (PSO) 3050 on the continuity of healthcare for prisoners says that events such as attending court, sentencing at court or being questioned by police may have a significant impact on a prisoner's health. PSI 07/2015 on early days in custody says that there must be arrangements in place to assess prisoners whose status or demeanour may have changed after a court appearance. PSI 07/2015 does not specify that prisoners should be assessed after an invitation to an inquest, but it is clear that a request of that nature may raise a prisoner's anxiety, especially given the nature of Mr Langdell's offence.

94. We appreciate that Mr Langdell had been asked on around 2 December to attend the inquest into his victim's death but gave staff no indication at the time that his risk had increased because of this. We also note that it was on 2 December that Mr Langdell started to refuse taking his medication. We cannot say whether this was a coincidence or a direct consequence of the Coroner's letter.

95. On 9 February, in response to a request from the Head of Security, an officer asked Mr Langdell if he wanted to attend the inquest. Mr Langdell declined. Although the Head of Security had warned the officer of the risk Mr Langdell might pose to the officer, there is no evidence that anyone considered Mr Langdell's risk to himself on

being told about the inquest. However, Mr Langdell told the officer that he had no thoughts of suicide or of self-harm at the time and the officer said if he had had any concerns, he would have started ACCT procedures.

96. The Head of Security said he did not contact the safer custody team about the Coroner's email and invitation to the inquest as he did not consider that it would present a risk to Mr Langdell. He said that Mr Langdell had not wanted to be involved with the inquest when he was asked three months earlier, and no concerns had been raised at the time about Mr Langdell's risk of self-harm.

97. Although this was not a considerable change in Mr Langdell's circumstances, it might have had an impact on his thinking. We consider that healthcare staff, officers on the wing and the safer custody team should have been told about it, but there is no evidence that this happened or that staff considered the potential impact on Mr Langdell, and whether he should be monitored under ACCT procedures.

98. We consider that given Mr Langdell's deterioration in behaviour, particularly in late January, staff should have been more aware of the potential impact on Mr Langdell of the invitation to attend the inquest. They should have given more consideration that the news might have increased his risk of suicide or self-harm. Although we cannot know whether it might have led to staff monitoring Mr Langdell under ACCT procedures, it was nevertheless a missed opportunity to identify any increased risk. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that prisoners are assessed after an interview with or invitation to attend inquest to assess their risk of suicide or self-harm.**

## Welfare checks

99. Before the pandemic lockdown, Mr Langdell would have had weekly sessions with his key worker. However, the scheme was suspended during the pandemic and replaced with welfare checks. Although Mr Langdell received welfare checks, we are concerned that there is no evidence that staff had any meaningful exchanges with him, although we accept that he often refused to interact with them.

100. However, we are concerned that the daily welfare checks completed were often recorded in the same manner in his prison record. They were often brief and generic, and some were almost identical, suggesting that no meaningful contact was made. Officer A acknowledged at interview that she would sometimes enter a standard entry while carrying out prisoner welfare checks, adding any additional information about a prisoner, if necessary. We suspect this applied to other officers as well. We found no evidence that officers made any significant effort to engage in meaningful conversation with Mr Langdell. Although we appreciate that he often did not want to engage with staff, there is no evidence that staff made a more concerted effort to engage with him when his behaviour deteriorated. We also note that there were no welfare checks recorded between 28 January and 10 February.

101. It is possible that the very restricted regime and the long periods Mr Langdell spent alone in his cell, without contact with staff or prisoners, and the news about the inquest, might have affected his mental health and contributed to him feeling that he

could no longer cope in prison. It is possible that more meaningful welfare checks might have identified this. We recommend:

**The Governor should ensure that staff understand the importance of having meaningful conversations with prisoners where possible, including when carrying out welfare checks during the restricted regime.**

## Razors

102. Mr Langdell's family asked why he had access to a razor blade, given his history of mental health and self-harm issues. Prisoners are allowed to have two safety razors. Prisoners subject to ACCT procedures are not allowed razors, although there are some exceptions to this. Because Mr Langdell was not subject to ACCT procedures at the time, there was no reason for him not to have razors. We note that he had not self-harmed since May 2019, despite having a razor for most of that time.

## Clinical care

103. The clinical reviewer concluded that the clinical care Mr Langdell received was of a mixed standard and not fully equivalent to that which he could have expected to receive in the community. The clinical reviewer identified some deficiencies in Mr Langdell's mental health care.

### *Mental health*

104. The clinical reviewer found that, overall, mental health services at Wakefield were appropriately responsive to concerns about Mr Langdell. However, the clinical reviewer considered that the mental health team missed an opportunity to review Mr Langdell after officers raised concerns about him on 29 January. The clinical reviewer also found that there was no evidence that Mr Langdell was discussed at the referral meeting on 1 February. The clinical reviewer concluded that given the concerns staff raised on 29 January, it might have been prudent to offer Mr Langdell the opportunity to engage with mental health services again.

105. However, the clinical reviewer considered that, as Mr Langdell had not previously engaged with services, it was likely that he would not have agreed to see the mental health team. The reviewer considered that mental health staff should have kept a full contemporaneous record, documenting the concerns raised in Mr Langdell's medical record, and should have reviewed previous entries. The clinical reviewer concluded that if concerns had persisted, ACCT monitoring should have been considered.

106. We make the following recommendations:

**The Head of Healthcare and the Governor should review the internal communication systems to ensure that clear processes are in place to refer prisoners to mental health services.**

**The Head of Healthcare should ensure that all staff are aware of the requirement to maintain full contemporaneous healthcare records**

### *Medication*

107. The clinical reviewer had no concerns about the management of Mr Langdell's medication. In an internal review, Practice Plus noted the lack of face-to-face contact from healthcare services with Mr Langdell about the decision to stop his promethazine prescription. Although we make no formal recommendation, the Head of Healthcare should ensure that there is improved transparency between healthcare staff and patients when prescriptions are changed.

## Learning lessons

108. We have identified a number of concerns in this report. We consider it is important that staff learn from our findings. We recommend:

**The Governor and Head of Healthcare should ensure that a copy of this report is shared with all staff named in this report and that a senior manager discusses the Ombudsman's findings with them.**

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