REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **HMP Wakefield** [redacted] 2. **Ministry of Justice – Rt. Hon Brandon Lewis MP, Secretary of State for the Ministry of Justice**
1	**CORONER** I am Kevin McLoughlin, Senior Coroner, for the Coroner area of West Yorkshire (East)
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroner's (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 26 February 2021 I commenced an investigation into the death of Carl Shaun Langdell, aged 31. The investigation concluded at the end of the Inquest on 21 October 2022. The conclusion of the Inquest was a narrative recording that death was attributable to haemorrhage from neck incision, and made findings in relation to Mr Langdell's management by the prison authorities and healthcare provider, along with a finding of suicide.
4	**CIRCUMSTANCES OF THE DEATH** On 11 February 2021 around 00.05 Carl Shaun Langdell was discovered in his locked, single occupancy cell with a significant wound to his neck. He was still able to speak [redacted] Despite emergency treatment he went into cardiac arrest. He was certified dead at 01:47 on Thursday 11 February 2021 at Pinderfields Hospital, Wakefield.
5	**CORONER'S CONCERNS** During the course of the Inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – (1) [redacted] (2) He had been identified by a consultant psychiatrist as at "chronic risk of suicide attempts/self-harm attempts which is likely to remain due to the nature of his personality disorder". (3) In January 2021 he was observed to be acting in a bizarre and agitated manner after refusing his prescribed medication for the previous month.

	(4) Despite this history and the known risk he was permitted under the prevailing rules at HMP Wakefield to be in possession [redacted] when alone in his locked cell overnight. (5) [redacted] (6) [redacted] (7) Evidence was taken at the inquest from a Governor who indicated a national proposal had been made [redacted]. If implemented this plan would remove one obvious risk.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within approximately 56 days of the date of this report, namely by Friday 16 December 2022. I, the Coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: 1. [redacted] 2. Practice Plus Group 3. [redacted], Midlands Partnership NHS Trust I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	21st October 2022 Signed Kevin McLoughlin Kevin McLoughlin Senior Coroner